REPORT RESUMES

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COMPREHENSIVE MENTAL HEALTH SERVICES FOR THE DEAF.
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A THREE YEAR PILOT PROJECT DESIGNED TO DEMONSTRATE THE VALUE AND FEASIBILITY OF PROVIDING COMPREHENSIVE MENTAL HEALTH (PSYCHIATRIC) SERVICES FOR THE DEAF ESTABLISHED A CLINICAL UNIT FOR THE DEAF WITH INPATIENT, OUTPATIENT, AND AFTERCARE SERVICES. THE CLINIC SERVED 50 PATIENTS (MINIMUM AGE 16) IN THE WARDS AND 96 PATIENTS (ALL AGES) IN THE OUTPATIENT SERVICE DURING THIS PERIOD. ALL CLINIC PERSONNEL WERE TRAINED IN MANUAL COMMUNICATION AND THIS FACILITATED DIAGNOSES AND TREATMENT OF THE PATIENTS. GROUP THERAPY WAS FOUND TO BE A VERY EFFECTIVE PROCEDURE WITH DEAF PATIENTS. OCCUPATIONAL THERAPY AND VOCATIONAL PLACEMENT SERVICES WERE PROVIDED IN SOME CASES. THIS PROGRAM ENABLED DISCHARGE OF ALMOST 50 PERCENT OF THE WARD PATIENTS AND FACILITATED IMPROVEMENT IN ONE-FOURTH TO ONE-THIRD OF THE OUTPATIENTS. THE SUCCESS OF THIS PROJECT LED TO PERMANENT ESTABLISHMENT OF THE MENTAL HEALTH CLINIC FOR THE DEAF. IMPORTANT AREAS FOR FUTURE RESEARCH ARE THE DEVELOPMENT OF TECHNIQUES FOR PREVENTIVE PSYCHIATRY AND AN EXPLORATION OF THE PROBLEMS OF REHABILITATION FOR THE DEAF, ESPECIALLY THE NEED FOR HALFWAY HOMES. CASE HISTORIES ARE PRESENTED AS ARE PROTOCOLS OF THE GROUP THERAPY SESSIONS. FIGURES, TABLES, CHARTS, RECORD FORMS, AND OPERATING PROCEDURES ARE AVAILABLE IN THE APPENDIX. A 95-ITEM BIBLIOGRAPHY IS INCLUDED. (RS)

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COMPREHENSIVE MENTAL HEALTH SERVICES FOR THE DEAF

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Department of Medical Genetics
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Comprehensive
Mental Health Services
For The Deaf

Comprehensive Mental Health Services For The Deaf

John D. Rainer, M. D. *and* Kenneth Z. Altshuler, M. D.

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
OFFICE OF EDUCATION

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Department of Medical Genetics
New York State Psychiatric Institute
New York Columbia University 1966

This monograph represents the final summary of the Clinical Demonstration of Comprehensive Mental Health Services for the Deaf (RD-1197), which has been generously supported since January 1963 by the Vocational Rehabilitation Administration, U. S. Department of Health, Education, and Welfare.

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Dedicated to

PROFESSOR FRANZ J. KALLMANN

(1897-1965)

who with vision and insight broke new ground in establishing the concern of psychiatry for the deaf.

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PREFACE

In this monograph, the authors describe the pilot project on Mental Health Services for the Deaf begun in 1963 by the Department of Medical Genetics of the New York State Psychiatric Institute. This project represented the fruition of the clinical recommendations which were made in the book *Family and Mental Health Problems in a Deaf Population*, the final report of the previous eight-year research, clinical, and training program. In turn, the present work has generated the establishment of a permanent psychiatric unit for the deaf under the New York State Department of Mental Hygiene, a most important milestone in medicine and rehabilitation.

We wish to express our deepest gratitude to those persons in Federal, state, and local agencies concerned with problems of the deaf who assisted and cooperated in this program. Especially we wish to acknowledge our indebtedness to Dr. Christopher F. Terrence, formerly Acting Commissioner, now First Deputy Commissioner, New York State Department of Mental Hygiene; Dr. Henry Brill, former First Deputy Commissioner, now Director, Pilgrim State Hospital; Dr. Alfred M. Stanley, Director of Rockland State Hospital; and Dr. Lawrence C. Kolb, Director of the New York State Psychiatric Institute. Their faith, encouragement, and support, and their expert and experienced advice contributed immeasurably to the successful development of the project.

We gratefully acknowledge the support of the Vocational Rehabilitation Administration, U.S. Department of Health, Education, and Welfare. A three year clinical demonstration grant received from that agency in January 1963 implemented our recommendations and made the program possible. Representatives of that agency whose aid and attention were invaluable included Dr. Mary E. Switzer, Commissioner; Dr. William Usdane, Chief, Division of Research Grants and Demonstrations; Dr. J. Keith Graham, Executive Secretary, Sensory Disabilities Research Study Section, and Dr. Boyce R. Williams, Consultant, Deaf, the Hard of Hearing, and the Speech Impaired. Equally helpful at all times were representatives of the New York State Department of Education, headed by Mr. Adrian Levy, Assistant Commissioner for Vocational Rehabilitation.

There are no words to express our sense of sorrow and loss at the untimely death of two persons so intimately associated with this project that it is hard even now to conceive of their passing.

Dr. Paul Hoch, as Commissioner of Mental Hygiene, with his foresight and progressive spirit, incorporated into his master plan for the mental hygiene system of the State of New York provision for special units devoted to the treatment of the deaf, and thus paved the way for this pilot project and the permanent program which succeeds it. He died suddenly in December 1964, leaving many, many lasting achievements.

As for Dr. Franz J. Kallmann who initiated the entire mental health program for the deaf and directed both this project and its predecessor until his death in May 1965, it is hard to say whether he is missed most by the scientific and medical community here and abroad, by his friends and co-workers, or by all the patients and their families, hearing and deaf, whose interests he personally furthered by time-consuming devotion. He longed to see his work develop: he should not have had to leave so soon.

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PART ONE

GENERAL DESCRIPTION OF THE DEMONSTRATION PROJECT

Chapter 1

BACKGROUND, AIMS, AND OBJECTIVES

The three-year pilot project described in this volume was designed to demonstrate the value and feasibility of providing comprehensive mental health services for the deaf on a regional basis. Its most significant sequel has been the establishment of a permanent psychiatric unit for the deaf by the Department of Mental Hygiene of the State of New York, comprising ward and clinic services, both staffed by specially trained personnel, where patients and staff members are capable of communicating manually with one another. This new program is the first of its kind in the country, if not the world. It is hoped that the present report embodying the experience of the demonstration project will encourage and help other administrations to take steps in the same direction.

Background

The clinical deafness project was preceded by close to eight years of activity focused upon the family and mental health problems of persons that either were born deaf or became deaf before acquiring the elements of verbal communication. In April 1955, a three-pronged program had been organized at the New York State Psychiatric Institute under the direction of Dr. Franz J. Kallmann. Designed to explore this new area of psychiatric interest, the program emphasized research, clinical management, and training.

To provide psychiatric diagnosis and treatment for the deaf, it was first essential to gain an intimate knowledge of their potential and actual life performance levels in the areas of family living and vocational and social adjustment. Guidelines for understanding adequate and inadequate performance were drawn by studying the data of hundreds of intensive interviews with separate deaf families in the community; by comparing a series of deaf twins with their deaf or hearing cotwins; by questioning the entire deaf population of the state to determine marriage and fertility patterns; and by studying deaf persons with various forms of extreme maladjustment as well as those who had achieved outstanding success.

Armed with this basic knowledge gained at first hand, the psychiatrists in the project opened the doors of a pilot clinic which offered the deaf in emotional distress all of the effective diagnostic, treatment, and preventive methods available to the hearing population. Between 1955 and 1963, over 200 deaf persons applied to the clinic, and specialized techniques of examination, diagnosis, and treatment were developed. Genetic counseling, sorely needed by the deaf, was also available as new data further illuminated the patterns of hereditary deafness.

Experiences in the clinic soon indicated the difficulties that existed for deaf psychiatric patients who needed hospital treatment. Personal surveys of the 21 state mental hospitals in New York revealed at any one time a total of about 230 deaf patients in all of the hospitals, about half of them schizophrenic. In most cases those patients were unable to communicate with the staff or other patients. More often than not they had reached a dead end, and tended to remain hospitalized for considerably longer periods than their hearing counterparts.

The findings of the initial study were made available in a series of reports and in the volume "Family and Mental Health Problems in a Deaf Population" (66). That monograph concluded with a number of recommendations. None was more urgent than the need to establish comprehensive mental health services, both for clinic patients and for those requiring hospitalization. The further development of psychiatric care for the deaf, especially inpatients, depended largely upon the opportunity for patients to communicate with each other and with doctors and hospital staff in a well-coordinated administrative setting.

At the close of the pilot project, it was announced with much pleasure and pride that a clinical demonstration program for the evaluation of comprehensive mental health services for the deaf would be supported by the Vocational Rehabilitation Administration, beginning January 1, 1963. The Commissioner of Mental Hygiene, the late Paul H. Hoch, designated Rockland State Hospital in Orangeburg, New York for the inpatient service; aftercare facilities and outpatient services were to remain at the New York State Psychiatric Institute in New York City.

Only by taking advantage of an entire state's facilities could such a unit function at the highest professional level. It is important, therefore, to understand the administrative setting and the geographical and physical locales into which this special program was to be fitted. The State of New York administers its psychiatric facilities under the Department of Mental Hygiene, headed by a Commissioner and comprising a number of divisions and special programs. There are 21 state hospitals for the mentally ill caring for over 108,000 patients, as well as 11 state institutions for the mentally retarded with over 26,000 patients. These hospitals and institutions are geographically distributed throughout the various regions of the state, with more than 400 miles separating the most divergent ones. The Department also maintains aftercare clinics at the hospitals or, in New York City, at special locations in the various boroughs. As a rule, patients are considered to be on convalescent status during their first year after leaving the hospital, and are required to report regularly to these clinics.

The New York State Psychiatric Institute, with only a few hundred beds, is the state's center for research and teaching in psychiatry. It houses the various research departments including the Department of Medical Genetics under whose aegis the entire deafness work has been conducted. The Institute is also associated with the College of Physicians and Surgeons, the medical school of Columbia University, and with the Columbia-Presbyterian Medical Center and its many hospitals and clinics. Rockland State Hospital is situated 20 miles from the Institute and can be reached in 30 minutes by car or one hour by bus. Located on the west side of the Hudson River and situated in a rural setting on almost 700 acres, it is also easily accessible from other parts of the state via the New York State Thruway. The hospital has excellent clinical, research, and recreational facilities and cares for over

6,000 patients, not counting more than 2,000 on convalescent care. This hospital thus represented an excellent choice for the inpatient services of the project for the deaf.

Local communities in New York State (cities and counties) also maintain psychiatric observation wards and mental hygiene clinics. New York City administers four psychiatric teaching hospitals, and all of them include psychiatric admitting and observation services.

The mental health law of New York State was modernized on September 1, 1965 with two basic goals: to regard admissions to mental hospitals as medical rather than judicial dispositions and to provide additional safeguards for the protection of the civil liberties of these patients. The new policy encourages informal and voluntary admission to treatment-oriented facilities and the conversion of all involuntary patients to the status of voluntary admission. In line with these policies, a Mental Health Information Service has the duty of informing patients of their rights and helping them in any legal procedures. Volunteer groups are encouraged to visit hospitals and every step is taken to remove the stigma of mental illness.

It is within this total framework that the demonstration unit for deaf mental patients was planned, came to fruition, and led finally to the establishment of permanent state-supported services. The unit was designed to serve the downstate area (as far north and west as Utica) with approximately 13 million people, or three-fourths of the state population, of whom more than 13,000 are deaf. This area is served by 15 state mental hospitals, five state schools for mental defectives, and seven schools for the deaf, none of which has specialized psychiatric facilities for deaf patients. Actually, since the project provided the only psychiatric unit for the deaf in the entire state, it accepted referrals from all of New York as well as requests for diagnostic evaluation from every part of the country.

Aims and Objectives

The clinical unit was designed to illustrate certain essential requirements for comprehensive psychiatric services for the deaf in a densely populated area such as downstate New York State, namely that coordinated inpatient, outpatient, and aftercare services were needed; and that such services could be effectively organized within an existing mental hygiene system on a statewide basis. By setting a pilot program into full operation, it was planned to demonstrate that such a specialized psychiatric unit might be not only the most appropriate, but also the most economical way of dealing with the particular emotional, rehabilitative, and family problems of a deaf population.

As the first step, the principle of special psychiatric services for the deaf was adopted in the master plan of the New York State Department of Mental Hygiene. The demonstration program could then be organized within the framework of the state system and with the support of the Vocational Rehabilitation Administration.

In outline, the unit was planned to consist of a vertically organized inpatient, outpatient, and aftercare facility expected to develop the following clinical services: diagnostic evaluation of psychiatric disorders in the deaf population of the area (as well as selected patients referred from other parts of New York State), with emphasis on early detection and possibly prevention of severe psychopathology; comprehensive and fully coordinated treatment procedures at the inpatient and outpatient levels, including psychotherapy and pharmacological and other somatic procedures; suitable occupational and group therapy programs for hospitalized patients; and consultative community service with family guidance programs and counseling facilities, including the possible prediction of genetically determined forms of deafness.

Methods of individual psychotherapy and ambulatory drug treatment were evolved during the course of the earlier project and described in its final monograph report. However, many forms of treatment could not be fully explored without a ward inpatient setting. These included the important potential of a therapeutic community, milieu therapy, group therapy, recreational therapy, and occupational therapy, intensive drug therapy in doses requiring constant supervision, and somatic therapy (electroconvulsive treatment, insulin). Moreover, ways of dealing with seriously disturbed deaf mental patients could only be developed after a psychiatric ward was established.

It was planned to continue the outpatient clinic with emphasis on improving methods of diagnosis, treatment, and marriage and parenthood counseling for patients and selected families referred from the deaf community.

A further objective of the program was to investigate methods for providing vocational rehabilitation, social service, housing, and other aftercare services of this nature for discharged patients to supplement their psychiatric follow-up. As will be seen, this objective could be achieved only on a limited scale; by the end of the demonstration period, it was clear that organization of these services as well as certain aspects of preventive psychiatry would have to form the basis for a third demonstration project to be built upon the program described in this volume.

From the point of view of the community, a very important aim of the unit was to aid various agencies in evaluating their deaf clients. These included welfare offices, religious and social organizations for the deaf, the Division of Vocational Rehabilitation, courts and parole officers, general hospitals and clinics, and private physicians.

None of the clinical functions of the program could be expected to succeed without a corps of trained persons familiar with the particular problems of deaf patients and able to communicate with them. Therefore professional and other ward employees would have to be continuously trained in these special skills and areas of familiarity. Moreover, very few specialists in the nation had the kind of knowledge provided by experience on such a project; and if the kind of specialized service for the deaf described herein were ever to be extended to other parts of the country, such knowledge would have to be disseminated. A final important goal of the project therefore was to recruit personnel from all areas in psychiatry, rehabilitation, nursing, and allied fields, and train them to work with the deaf.

In line with these pioneering and educational functions, the project—even before its outset—aroused considerable interest among professional workers from other states and from foreign countries. During the course of the project, these individuals visited the unit and expressed the desire to establish similar services in their own regions.

Chapter 2

ORGANIZATION OF PSYCHIATRIC SERVICES

In order to function as a truly comprehensive mental health service for the deaf, the project and its facilities were organized so that activity was simultaneously directed to prevention, diagnosis, outpatient treatment, inpatient treatment, rehabilitation, and aftercare.

Prevention

In the area of preventive psychiatry, the clinical program could only touch the surface, and serve as a pilot exploration to determine goals for the future. Since so many emotional problems can first be picked up in the childhood and adolescent years, psychiatric consultations and group discussions on a limited basis were held at one of the nearby schools for the deaf, with one of the project's psychiatrists visiting the school one morning a week during the academic year. In conjunction with the school psychologist and social worker, he arranged interviews with students who showed incipient emotional problems or behavior disorders. Conferences with the supervising teachers and house parents and short term psychotherapeutic contacts with the students served both trouble-shooting and preventive purposes. Adolescent students with problems of social misbehavior or negative attitudes to authority and to each other met in groups each week for therapeutic discussions designed to increase their self-awareness and awareness of others (cf Chapter 14).

Another form of preventive psychiatry explored during the project was the organization of lectures and discussions for groups of deaf laymen, parents of deaf children, and workers with the deaf. By emphasizing general principles of mental hygiene and pointing out the danger signals of psychiatric disturbances, these talks imparted valuable knowledge which both professionals and laymen could utilize in their several roles.

Diagnosis

On the level of diagnosis, consultations were arranged for deaf patients residing at home, and for deaf patients in other mental hospitals. Referred to the clinic by vocational rehabilitation agencies, physicians, deaf organizations, and their families, the ambulatory individuals with behavior or family problems were seen by a psychiatrist or psychologist by appointment, usually at the New York State Psychiatric Institute. Evaluation reports with recommendations were prepared, conferences were held with referring sources, and a treatment program in the outpatient clinic was set up when indicated. Patients in state, city, or county hospitals were reported to the project as soon as they were admitted. They were subsequently visited by the project staff for the purposes of diagnosis, lending assistance to the hospital physicians, and possible transfer to the inpatient unit. By means of periodic visits to these various hospitals, it was possible to keep currently informed about deaf patients there, to confer with hospital directors and ward physicians, and to consult with local groups of deaf citizens.

Facilities

The inpatient unit was opened on January 1, 1963 following the selection of a spacious and suitable ward at Rockland State Hospital in Orangeburg, New York. This hospital has its own excellent clinical and research facilities, as well as access to the community mental health services of suburban Rockland County and New York City. The ward selected had space enough to accommodate male and female dormitories, with a common day room and ancillary therapeutic facilities (cf Chapter 5).

Admission Procedures

Administratively and clinically, this ward occupied a unique position in the hospital. Deaf patients were selected and admitted from the entire State of New York after careful evaluation. After they were admitted, they received an initial workup according to the rules of the Department of Mental Hygiene with mental and physical examinations and laboratory studies. A financial investigation was conducted to determine what fees, if any, were to be paid. The specially trained professional staff from then on determined individual programs for treatment and rehabilitation, handled specific management problems, and recommended discharge or transfer of patients, while the director of the hospital assumed the responsibility for overall supervision, and for decisions on hospital privileges, home visits, and discharges.

Records

General statistical records were maintained, as with all patients in the state hospitals, and periodic documentation of each patient's progress was charted. In addition, a more complete set of records for each patient on the special ward listed more frequent observations on his progress, management, and diagnostic evaluation, both clinical and psychological. A large-size ledger with a separate sheet for each patient recorded psychiatric and medical information, past history, and previous contacts with the Mental Health Project for the Deaf, the length of time the patient remained with the project, and procedures that were recommended for aftercare. Decisions reached following discussion of patients at weekly staff conferences were also entered into this ledger. These decisions covered changes in diagnosis and continuing recommendations regarding treatment and rehabilitation. The patients were rated prognostically on a four point scale; and their level of psychosexual maturity at various stages was estimated according to an arbitrary scale from one to ten. The ledger thus provided a current summary of patient data and a cumulative summary of the total ward experience.

The project also kept files on all patients in other mental hospitals throughout the State, containing duplicates of their case histories. A separate card system carefully maintained at the Psychiatric Institute since 1955 listed all deaf persons living in New York State both alphabetically and by geographical region.

Rehabilitation and Aftercare

The final stage in the care of patients included rehabilitation and continued aftercare. Although a complete and elaborate program was beyond the scope and resources of this project, the groundwork for such a program was established. Provision was made to offer regular psychiatric treatment sessions, family consultations, and some degree of aid in housing and job placement for patients who were discharged to convalescent care, after their rehabilitation programs had been planned and discussed by the psychiatric staff. Before the patients were placed on convalescent care, lengthy arrangements had to be made with their families. In the case of patients with no immediate family, the staff had to assume the difficult task of finding suitable housing with persons who would provide supervision and access to other deaf tenants. Meanwhile, employment possibilities had to be scouted and trial placements had to be made before the patient was finally released. Manipulative vocational aptitude tests aided in the search for placement. Each patient's record in occupational therapy, typing, and pre-industrial shop was considered with regard to regularity of attendance, quality of work performed, reaction to authority and to peers, dependency needs, and frustration tolerance.

Follow-up visits to the homes and families of patients who were discharged to convalescent care were made at least once a month, while the patients themselves reported weekly to a staff psychiatrist for aftercare treatment. Cooperation with schools for the deaf and religious and welfare associations was achieved in the course of the rehabilitation program.

Thus, basic guidelines were established for an intensive post-hospital rehabilitation service and the efficacy of various approaches to problems presented by individual cases was explored. This pilot program paved the way to the next phase of psychiatric planning for the deaf with rehabilitation as its principal focus.

Chapter 3

RECRUITMENT AND STAFFING

The operation of a complex, diversified, and specialized mental health service requires a large, well-integrated team of professional and semi-professional workers utilizing their various interdisciplinary skills and united by a human concern for and sympathetic understanding of the problems of the deaf. Since the recruitment of such a staff is of primary importance, some of the details regarding this phase should be of value in documenting the program.

Organization of Staff

The project was organized and directed by Dr. Franz J. Kallmann, Chief of the Department of Medical Genetics at the New York State Psychiatric Institute. After Dr. Kallmann's untimely death in May 1965, Dr. John D. Rainer was named Project Director and Acting Chief of the Department. At the outset of the program, the professional team consisted of the staff members of the Department of Medical Genetics who had been concerned with the problems of the deaf since 1955 (Drs. Kallmann, Rainer, and Kenneth Z. Altshuler). This group continued to exercise overall supervisory and training functions for the entire project.

When the inpatient ward was opened at Rockland State Hospital, additional members were added to the staff. These persons included a full-time supervising psychiatrist and other psychiatric workers, a head nurse and an assistant, a full quota of ward attendants, and a corps of specialists experienced in occupational, recreational, and group therapy, psychological examination, and rehabilitation. In addition, resident physicians in psychiatry attached to the New York State Psychiatric Institute spent one month of their training on the special ward, to familiarize themselves with its unique clinical problems. The entire staff received regular training in the sign language and in the special problems of the deaf.

The psychiatric staff of the clinical inpatient unit and the consultative and training group at the Psychiatric Institute were responsible for conducting outpatient clinic services, family guidance work, hospital consultations, and aftercare treatment of discharged patients.

As in every mental hospital, recruiting an elite group for the nursing staff was as difficult as it was important. In addition to providing the physical plant and underwriting the cost of new construction, equipment, daily patient care, and many clinical workers at all levels, the Department of Mental Hygiene chose five of its most capable and experienced ward attendants to serve as the backbone of the duty roster needed for 24-hour patient care. These were supplemented by nine attendants chosen from applicants responding to a widespread search for well-motivated and dedicated persons. New attendants received a three week training course in general ward duties and began learning manual communication at once. Responsibility for patient care and execution of the clinical treatment program was in the hands of a head nurse and a practical nurse, aided by the 14 attendants.

Occupational therapy, an integral part of the program, was under the guidance of an occupational therapy instructor and supervised by the psychologist and the rehabilitation counselor. The function of the rehabilitation counselor was a complex one since it required close familiarity with all of the patients at the prevocational and vocational levels.

Two highly skilled part-time workers were employed to increase the communication skills of patients and staff. A teacher of the deaf came twice weekly to help selected patients in the elements of English grammar, vocabulary, and reading. This made it possible to admit some patients with a limited education who needed this kind of training along with their psychotherapeutic regimen. Another specialist came weekly to conduct beginning and advanced classes for the staff in manual communication (finger spelling and sign language). He was also able to provide oral instruction for some of the deaf patients.

The ward secretary, in addition to her secretarial duties, coordinated the contributions of the interdisciplinary team. All information pertaining to the various aims of the project was channeled through her office where it was integrated into the files and records.

Staff Conferences

The entire professional staff of the project attended regularly scheduled conferences on clinical and administrative matters. These conferences included:

1. Weekly clinical meetings run by the project director. These conferences were devoted to diagnostic and prognostic evaluations of each patient at regular intervals, and the formulation of new or revised short and long term treatment and rehabilitation programs. New patients were reviewed in these clinical meetings within two weeks after their admission. Outpatient and aftercare problems were also reviewed, patients were selected for future admission, and staff visits to deaf patients in other hospitals were scheduled.
2. Monthly administrative conferences in which the project director discussed the direction of the program as a whole and the initiation of new techniques and phases of work.
3. Weekly ward rounds conducted by the supervising psychiatrist. Current problems in patient management, treatment, and evaluation were reviewed and regular notes on the progress of each patient dictated.

Conferences for the ward attendants were held once a month. These meetings were designed primarily to provide a broad understanding of the goals of the project and a consistent approach to patient care and ward management. Problems in these areas were discussed, the dynamics of interpersonal relationships among both patients and staff were evaluated, and relevant information pertaining to the patients' immediate problems and needs were conveyed to the nurses and attendants. By encouraging staff suggestions and participation, these conferences stimulated the dedicated team approach which so greatly improved the operation of the unit.

Chapter 4

REFERRAL, SELECTION, AND EVALUATION OF PATIENTS

Sources of Referral

The survey described earlier, which had been conducted from 1955 to 1963 by the Department of Medical Genetics, established the total number of deaf persons in the State of New York, and listed all deaf patients located in mental institutions throughout the State. These patients had been visited regularly; and the project maintained files on their histories, diagnoses, present condition, and course in the hospital. During the same period, an active outpatient service had been consulted by over 200 deaf patients, referred by deaf organizations, community agencies or hospitals, family, and friends. Thus, at the onset of the clinical program in 1963, a large pool of patients and existing referral sources was available.

Selection Procedures

When the project was activated, directors of all admitting centers in Metropolitan New York and institutions throughout the state were requested to cooperate by notifying the project director when a deaf person was admitted and by supplying a copy of the admission summary. When an admission notification was received, a project staff member visited the hospital to evaluate the patient. In addition staff members visited each hospital at regular intervals to keep close track of the patients who awaited transfer to the unit.

During the later stages of the project, as policy was solidified, the Department of Mental Hygiene issued a special order* which became a permanent part of its Policy Manual and made it possible to transfer to the special ward any patient in a state mental hospital. Equally important, it provided for his return to the original hospital if it were eventually felt that he could neither receive further benefit nor be discharged. In view of the ward's limited capacity, the latter proviso was necessary to avoid eventual crowding with chronic patients. However, it should be noted that during the three years of the program only two out of 50 patients had to be returned to the hospitals from which they had come.

Evaluation of Inpatients

Once a patient was admitted to the special unit, evaluation of his progress began with his admission conference and continued regularly until his final disposition. Ordinarily, evaluation of a given method of treatment requires that it be compared with another method. An ideal way to compare the efficacy of the method for a given population is to assign the two treatments to random samples of the population, and indeed much evaluation of treatment is carried out in this way.

Other means of comparison must sometimes be invented, however, for various reasons. With human subjects, it is often impracticable or unjust to select at random persons who are to receive either the standard treatment or another form. In the present project, it was not desirable to list all deaf patients in the State of New York, and then select at random the patients to be transferred to the special unit for the deaf. Since the ward was limited in size, and held patients of both sexes, clinical and practical criteria were used in making the selection; once chosen, a patient received whatever treatment was considered most likely to help.

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* "*Clinical Deafness Unit at Rockland State Hospital:* Upon admission of a totally deaf patient to a mental hygiene institution, notification of such admission should be sent to Dr. John D. Rainer, Acting Chief of Psychiatric Research (Medical Genetics), Psychiatric Institute, 722 West 168 Street, New York City. As soon as a clinical summary is available, it should also be forwarded. If notification is received that the patient can be transferred to the Clinical Deafness Unit: 1) Permission should be obtained from the responsible relative; 2) An Order for Transfer under Section 10b of the Mental Hygiene Law should be obtained from the Central Office. When a patient so transferred has received the maximum amount of benefit from the deaf unit, another Order of Transfer under Section 10b of the Mental Hygiene Law will be obtained from the Central Office by the Clinical Deafness Unit, to return the patient to the hospital or school from which he came."

An alternate method of comparison is (a) to consider for each patient admitted to the ward what his prognosis would have been if he had remained in his previous hospital under standard treatment; (b) to compare this standard prognosis every three months with his actual condition as recorded in the special ward. The differences between his standard prognosis and actual condition, for one or more characteristics, may serve to measure the effect of special treatment.

The main advantage of this kind of evaluation lies in its statistical efficiency; the two observations—prognosis and recorded condition—are made on the same person, thus eliminating the variability between patients when separate groups are used.

The method has its disadvantages, however. One is that the patients are not randomly selected from all deaf patients; therefore inferences from the observed differences are not wholly representative. Another difficulty is that of making an objective prognosis. One way to reduce possible bias in the original prognosis is to take as an indicator the past history of patients, especially in the case of those who were previously hospitalized for long periods of time.

The weekly staff conferences designed for continuous evaluation reviewed every patient in order to recognize clinical changes, to compare his present condition with that in the previous hospital, to revise his prognosis at quarterly intervals, and to consider the possibility of week-end visits, extended home visits, or convalescent care.

As a general impression, psychiatrists who observed patients in the ward, outsiders as well as those deeply involved in its work, were amazed that patients could show so much clinical advancement, although virtually nothing could be done for them before they entered the unit. Many psychiatrists, for example, believed that group therapy would be impossible among deaf patients; however the results of that program were extremely rewarding (cf Chapter 8). The clinical progress of the patients and the daily experiences of the staff, more than anything else, led to a conviction that the mentally ill deaf require special psychiatric personnel and specialized clinic and hospital facilities, and that without these they would receive not poorer psychiatric care, but essentially none at all.

Referral of Outpatients

In the outpatient department 119 new patients were referred during the period of time covered by this report. With a hospital service available, the frustration of having to refer seriously ill patients to nonspecialized facilities was overcome and it was possible at last to deal effectively with their total psychiatric problems. Clearly there was need, both in the outpatient and the ward services, to deal more intensively in the future with the family, vocational, and social readjustment of the patients. In the meantime, it was encouraging to note that other agencies began to step up their social and vocational activities in order to mesh with the project's psychiatric program.

PART TWO

THE PSYCHIATRIC WARD

Chapter 5

WARD FACILITIES AND PROCEDURES

Physical Arrangements

The hospital ward chosen to accommodate the inpatient program was originally designed to house 50 female patients. It comprised one-half of an entire floor in a large treatment building and contained 6200 sq. ft. It was remodeled extensively to serve as the ward facility for 30 deaf patients, 15 female and 15 male, who would participate in the special program for the deaf.

The entrance to the ward leads into a large foyer off which radiate a visiting room, the patients' library, the dining room and kitchen, the nurses station, and a locker room. Extending from this foyer in one direction are the dayroom, female dormitories, and sunporch; in the other direction a long corridor leads to the male dormitories and the occupational therapy workshop.

Offices along this corridor accommodate the administrative, professional, and secretarial staff, and the social service and guidance counselors. This area also contains a conference room, an examination room, a soundproof audiometric laboratory, an interview room with a one way mirror, and an isolation room.

When the special ward was selected for the unit, the patients then occupying it had to be transferred to other wards or other hospitals, an administrative task of some magnitude. The extensive reconstruction and refurnishing of both ward and offices took nine months for completion. During this time equipment for occupational therapy was installed—looms, sewing machines, a kiln and potter's wheel, and woodworking, painting and tile-working equipment. A movie projector for specially titled films, a television set, table tennis, and outdoor sports equipment were provided for recreational therapy.

Procedures

On entering the unit, whether by transfer or direct admission, each patient was interviewed and evaluated by members of the specially trained psychiatric team, so that an individual program could be developed for him. He was then given a battery of psychological tests, specially modified for the deaf. A complete review was also made of his physical condition and neurological status, and his history was reviewed with reference to those factors pertaining to the nature of both his deafness and mental illness. If needed, further information was collected from the patient and the family.

Upon completion of this procedure, the data were presented and the patient interviewed at the staff conference on admissions under the direction of the project director or his associate. At this conference, a diagnostic evaluation, an estimate of rehabilitation potential, and a treatment plan were determined. These were recorded on a special form by the therapist assigned to work with the patient, in close consultation with the supervising psychiatrist. Every three months, the therapist prepared a summary to indicate the patient's advancement in therapy. At the weekly staff conference directed by the supervising psychiatrist, current problems and day-to-day evaluations were reviewed, with each therapist giving a progress report on the patients in his charge.

The workshop in occupational therapy on the ward became an important tool both for treatment and rehabilitation. In addition, arrangements were made for some patients to work in other shops and clerical training facilities of the hospital, in the laundry, on the grounds, in the community store, and so on. The recreational program included such items as subtitled movies and athletics (baseball, tennis, swimming). With the aid of the staff, the patients organized their own library.

The program in group therapy evolved dramatically as the patients developed from a rather non-communicative, inattentive, concretely thinking group, into one made up of persons aware of each other, observant, interactive, and making decisions about themselves.

Individual therapy was provided to each patient at a suitable level, according to the principles developed earlier in the program (66). However, results improved over those achieved previously with outpatients because now it was possible to correlate special psychotherapy with the group treatment and to work more intensively with each patient. Somatic (shock) treatments and pharmacotherapy were used when required. In addition, all the research and clinical facilities at Rockland State Hospital were available for special laboratory tests and medical treatment.

Families of patients could visit twice a week and they took advantage of the opportunity to confer with the members of the professional staff so that their attitudes toward the patients' treatment and eventual discharge could be modified in a positive direction. The hearing parents of deaf sons and daughters often required much reeducation, and group discussions among parents were initiated for this purpose.

Chapter 6

SURVEY OF PATIENTS: ADMISSIONS, DIAGNOSES, DISCHARGES

Admission Data

When the ward service opened its doors in April 1963, it received the first five patients, all females, ever to be treated on a special service of this kind. In January 1964, facilities were completed to accommodate 15 male and 15 female patients at any one time. By December 31, 1965, 50 patients (18 males and 32 females) had been admitted to the facility—fewer males since only females were treated during the first nine months.

The disposition of these patients as of that date is shown in Table 1.* It will be noted from this table that 22 patients were discharged to convalescent care during the three-year period. Of the others, only three patients had to be transferred out of the special ward to other wards or other hospitals. Two of these patients were suffering from severe organic disorders (grand mal epilepsy and hyperpituitarism) which necessitated extra nursing and medical care. The third patient, with sociopathic personality, had to be returned to his previous hospital because all attempts to control his sexual and aggressive behavior had failed. In addition, one patient died of uremia; she was 70 years old, the oldest patient on the ward, and had been in poor health at the time of admission.

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* For additional descriptive inpatient data, see Appendix A, Tables I-VI.

Of the 22 patients discharged to convalescent care, only two were subsequently readmitted. One of these patients was brought back to the ward for a few weeks because the living arrangement made for her did not work out. Subsequently other arrangements were made to discharge her to the care of a halfway house facility, and she has remained on the outside, living in an apartment and holding a part-time job. The other patient readmitted suffered a psychotic relapse which made it difficult for the relatives to keep her at home. She represented the only case of readmission on psychiatric grounds.

Diagnostic Groups

In Table II there are listed the major diagnostic groups to which the ward patients belonged. In some ways this grouping is not typical of the total New York State hospital population or even of deaf patients in New York State hospitals. Since it was necessary to select patients who could be expected to benefit from intensive treatment, senile and arteriosclerotic, severely organically impaired, or mentally retarded patients were largely excluded. The proportion of schizophrenic and cycloid psychoses is more representative, while other behavior disorders account for a particularly large category of patients.

TABLE I

Disposition of Hospital Patients: Admissions and Discharges

	Admissions	Read-missions	Discharges	Transfers	Death	On Ward as of 12/31/65
Male	18	–	4	1	–	13
Female	32	2*	18*	2	1	13
Total	50	2	22	3	1	26

*Includes one patient readmitted and shortly re-discharged.

In psychiatry, where diagnosis depends so much on patients' verbal accounts of their thoughts and feelings, the deaf present a special challenge. In the case of five patients on the ward, major changes were made after admission in diagnoses which had been reached elsewhere. The extensive use of sign language in interviewing patients and in daily contact with them

TABLE II
Diagnostic Distribution of Hospital Patients

	Male	Female	Total	Percent of Total Admissions to Special Ward	Percent of New York State Hospital Population	
					Deaf*	Hearing*
Schizophrenia	9	18	27	54	52.2	56.5
Psychosis with Mental Deficiency	–	2	2	4	18.2	3.7
Senile and Arteriosclerotic Psychosis	–	–	–	–	7.4	16.2
Cycloid and Involutional Psychosis	1	3	4	8	5.2	8.0
Organic Psychosis						
(a) with Retinitis Pigmentosa	–	–	–	–	4.8	
(b) Other	–	3	3	6	7.0	12.0
Other Behavioral Disorders	8	6	14	28	4.3	3.4
Undiagnosed					0.9	0.2
Total	18	32	50	100.0	100.0	100.0

*From *Family and Mental Health Problems in a Deaf Population* (J. D. Rainer et al., eds.), New York State Psychiatric Institute, New York, 1963.

helped to get to the core of their mental problems, but the difficulties were many and varied. Not all of the patients were proficient in using or understanding manual language. Often a final diagnosis had to be kept in abeyance until the patient had been taught effective means of communication. Such instruction, a unique service in an adult ward, was imperative for the success of the entire undertaking.

Because of the limited number of beds, the attempt was made to select patients who were suitable for intensive therapy and rehabilitation potential, and at first chronic, deteriorated patients were avoided. During the last year of the demonstration project, the new administrative policy referred to in Chapter 4 made it possible to admit on a trial basis some patients with a more chronic course. This policy was formulated so as to give these patients a chance to receive the intensive care available in the unit, to study the process of deterioration in long hospitalized deaf patients, and to assess them for possible rehabilitation.

Patterns of Discharge

The discharge pattern of the ward patients according to their age is represented in Table III. As an adult ward, the service established a minimum admission age of 16 years. A few patients below this age were housed in the adolescent and children's units of the hospital, spending some time during the day in the ward for the deaf. These youngsters are not included in the statistics. The largest number of patients belonged to the young adult group, 16-25 years. It is interesting to note that although the discharge rate for all other patients was close to 50 percent, the heavily represented young adult group had a discharge rate of only 25 percent. Two factors would seem to account for this comparatively low rate. First, the admission policy was kept most flexible for this age group with the result that patients were largely unselected, some representing the severest forms of psychiatric illness; and second, the practical problems involved in the placement and rehabilitation of some of these patients were especially formidable.

Due to the maturity lag associated with their sensory handicap, the deaf are slower to grow into relative emotional independence; thus deaf patients who are 16-25 years old in many ways resemble hearing adolescents. Moreover, many of these younger patients came to the unit with virtually no communication ability and with marked social limitations in addition to their psychiatric illness. They required a well-structured situation in order to function at an optimum level, and needed intensive training in language and communication. Premature attempts to discharge them to their own care would have invited disaster. In a number of cases their families refused to take charge of them when they were ready for release, and it was extremely difficult to find other understanding and sympathetic persons who would agree to take care of them. As the table indicates, the greatest number of patients who were employable, but unemployed, were in this age group. Very few employers were public-spirited enough to accept these individuals with multiple handicaps. This whole problem presented a challenge which required a concerted effort of all the agencies in the community working for the welfare of the handicapped.

In the group of older patients (36-45), the discharge rate was higher. Of 11 patients, five (or nearly 50 percent) were discharged. Three patients in this group had had several acute breaks in adaptation and a series of short-term hospitalizations; the other two patients had been hospitalized up to 23 years, but had little residual psychopathology. Three of the five were employed after discharge.

TABLE III
Distribution of Hospital Patients by Age and Employment Status

Age in Years	Total Admission	Discharged as of December 31, 1965				Ready for Discharge
		Total	Gainfully Employed	Employable	Non-employable	
16-25	21	6	2	3	1	7
26-35	11	5	1	2	2	1
36-45	11	5	3	2	–	1
46 and above	7	4	1	1	2	1
Total	50	20	7	8	5	10

Table IV shows the disposition of the patients on the service according to their age, length of stay, and years previously spent in other hospitals. It discloses some striking facts. Out of a total of 22 patients who came to the ward with little or no previous hospitalization, 17 (14 females and 3 males) were discharged, or put on convalescent care, or were ready for discharge in less than two years at the unit. Two of these females and one male were over 45 years of age. One of the 22 patients was transferred. It should be noted that most of the deaf patients newly admitted to any psychiatric hospital in New York State in the recent past have had little or no previous hospitalization. It thus seems safe to generalize that the success recorded here may be projected to future patients who will enter the deaf unit with no previous hospital history.

Generalization about results for patients who have previous hospital stays cannot be made with such certainty, as there was necessarily a degree of selectivity among patients transferred to the unit with long histories of hospitalization. Generally such patients fall into the older age groups; some who may have become attached to a hospital may not wish to be transferred, or they may have relatives nearby who refuse permission. Consequently, most patients who did come to the ward after a long hospitalization elsewhere were past middle age and often had no near relative. On the other hand, for the first two years of the project, transfer patients were also selected on clinical grounds for their rehabilitative potential. These selective factors notwithstanding, the uniformly high ratio of success achieved with the transfer patients may be a basis for optimistic prediction with the more chronic patient in general. The following examples are cited:

a) Five female patients out of 10 who entered the unit after five years or more of previous hospitalization were discharged after less than three years in the unit. One patient had previously spent 25 years in other hospitals. Of the five chronically hospitalized female patients not discharged, only two are still in the unit; one died, one was transferred, and one left the country.

b) Five male patients out of eight who entered the deaf unit after five or more years of hospitalization were discharged after less than two years. One patient who had been in hospitals 23 years before he came to the ward was put on convalescent care after only three months. Another male patient who

TABLE IV

Disposition of Patients in the Unit for the Deaf According to Age, Length of Stay, and Years Previously Spent in Other Hospitals

Females

Age	Years in Deaf Unit	Still in Deaf Unit								Discharged or on Convalescent Care			
		Need Further Hospitalization				Ready for Discharge							
		Previous Hospitalization, in Years				Previous Hospitalization, in Years				Previous Hospitalization, in Years			
		Under 1	1-4	5-9	10 or over	Under 1	1-4	5-9	10 or over	Under 1	1-4	5-9	10 or over
16 - 24	Under 1/2	2			1								
	1/2 to 1									2			
	1 to 2					1				3			1*
	2 to 3					1							
25 - 34	Under 1/2		1										1
	1/2 to 1									1			
	1 to 2		1										
	2 to 3							1					
35 - 44	Under 1/2	1								1			
	1/2 to 1		1							2			
	1 to 2									1		1	
	2 to 3		1		1							1	
45 or over	Under 1/2								1	1			
	1/2 to 1									2***			1
	1 to 2												1**
	2 to 3												

TABLE IV (Continued)

Males

Age	Years in Deaf Unit	Still in Deaf Unit								Discharged or on Convalescent Care			
		Need Further Hospitalization				Ready for Discharge							
		Previous Hospitalization, in Years				Previous Hospitalization, in Years				Previous Hospitalization, in Years			
		Under 1	1-4	5-9	10 or over	Under 1	1-4	5-9	10 or over	Under 1	1-4	5-9	10 or over
16 - 24	Under 1/2	1						2					
	1/2 to 1		1			1					1		
	1 to 2							1**					
	2 to 3			1									
25 - 34	Under 1/2												
	1/2 to 1		1				1			1			
	1 to 2			1									
	2 to 3			1									
35 - 44	Under 1/2			1									1
	1/2 to 1												
	1 to 2												
	2 to 3												
45 or over	Under 1/2									1			
	1/2 to 1												
	1 to 2								1		1		
	2 to 3												

* Left the country
** Transferred to other ward
*** One of these patients died

had been in hospitals 20 years was discharged after less than two years in the deaf unit.

Beyond anything else, the rehabilitation of these chronically hospitalized patients demonstrated the value of the service in salvaging human potential. This alone would seem to justify the cost and effort required.*

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* For more detailed data on patients of special medical or genetic interest, see Appendix B.

Chapter 7

GOALS AND METHODS OF TREATMENT

The overall goal in the treatment of deaf psychiatric patients was to provide therapeutic services which were at least equivalent in professional standard to those available for the hearing. As the primary and persisting handicap for the deaf is one of communication, the presence of a staff versed in manual language was an important step in achieving such equal services. Yet even with this valuable aid, the warps engendered by a lifetime of handicapped experience, added to the several specific emotional ills, required a wide variety of efforts and a total push program to approach the desired end. Thus, the treatment methods were multi-disciplinary and eclectic. The different forms of therapy included individual and group psychotherapy, drug and somatic therapies, and a favorable ward milieu. Adjunctive treatment included occupational and recreational therapy, a school program for the expansion of communicative skills and general knowledge, rehabilitation counseling with some prevocational experience, and parties and other social activities organized with the help of volunteers.

The patients in the special unit made up a heterogeneous group, varying widely with respect to age, chronicity and types of illness, intelligence, depredations made by illness on intellectual potential, educational and vocational history, and communication and social skills. Each patient entering the unit had to be assessed in terms of these factors in order to formulate treatment and rehabilitation goals. The psychiatric and psychological evaluation suggested the treatment modalities that should receive the most stress for a given patient, and the limits within which each patient could be expected to improve.

Wherever it was deemed feasible, a patient was assigned to a psychiatrist or the ward psychologist for individual therapy. Depending on the capacities and characteristics of the patient, the approach utilized by the therapist was either mainly insightful or supportive and didactic. The development of a human relationship with the therapist, one in which the patient felt him to be helpful, reliable, and interested, was necessary at all times. In most cases, direct help was provided by manipulating the environment at some time during the course of treatment. Insight-generating therapy was least frequently the principal method, since its success requires a patient who is highly motivated for change, one who has good frustration tolerance, capacity to work toward long-term goals, and at least average verbal-cognitive skills. Even healthy deaf persons are often deficient in these characteristics. Among the patients in the hospital the deficiencies were far more pronounced.

Case Histories to Illustrate Treatment

What constitutes a measure of change in patients is an elusive problem in all psychiatric practice, as uncertain in the deaf as in the hearing (34, 47, 73, 86). The project made a preliminary foray into the use of objective measures of interactions between patients for this purpose, but the results of this research would need considerable refinement before becoming generally applicable, even if they should be most successful (cf. Chapter 9). Meanwhile, the conservative though non-specific criteria of dischargeability and return to function in the community were considered to be the best measures of improvement. The following case abstracts are presented to illustrate the range of problems encountered, the specific applicability of various psychotherapeutic techniques, and the level of success attained. They are organized to demonstrate first, the schizophrenic cases, as typical of psychotic conditions; second, a range of other diagnostic groupings, some characterized as having a primitive type of personality; and last, an interesting type of impulsive borderline case seen more commonly perhaps among the deaf than the hearing.

Schizophrenia

Schizophrenia is the most common psychiatric disorder in the psychotic range, with an expectancy rate of about one percent for the population at large (1, 39, 40). The fundamental disturbances are a splitting in thought processes, in concept formation, and in emotional reactions and expression. Instead of being rational and logical, thoughts may be disconnected, rambling, at times incoherent. Emotional tone may be shallow and inappropriate to what is expressed. The patient will often repudiate reality in whole or part and misconstrue the world in terms of personalized delusions or hallucinations.

The work of the earlier project established that schizophrenia in the deaf was the same entity as observed in the hearing, and that deafness alone had little if any influence on the likelihood of developing this type of illness (10, 12, 71). The case abstracts presented below confirm the potential for treatment of schizophrenia in the deaf (cf. Chapter 11). In the second case, insightful work was possible, whereas the first required a greater reliance on the relationship aspect of treatment, made palatable to the patient by means of special techniques. Both patients also required medication and direct assistance with outside relationships, and in these ways were typical not only of deaf schizophrenics but of the group of deaf inpatients as a whole.

Case 1: C. D., a 45 year old female patient, was the only child of a middle-class family, and her deafness was acquired at the age of five following an attack of whooping cough. She was intellectually gifted and had graduated from an elementary school for the deaf, a hearing high school, and an IBM training school. An athletic woman, she also won trophies in sports. After working for several years as a computing machine operator, she left her job to care for her mother who had become ill and died soon after.

Earlier, at the age of 30, she had married, without love, a deaf mechanic, but was happy in the marriage for only a few months. She felt that she and the son she bore him meant much less to her husband than his mother or car, that he understood neither women nor marriage, and that he did not respect her. There were innumerable arguments, they beat each other several times, and finally her husband left to live elsewhere though he continued to provide her with a small monthly allowance. Since then she lived alone with her deaf child, maintaining a meticulous home, and managing to live within her limited means by very careful budgeting.

When the son was 13 she returned to work to supplement her income. She soon began to feel that her employer had a personal interest in her and was keeping her under constant surveillance by the use of electric devices. Colors and numbers took on a delusional symbolic significance, each having a specific meaning for her. She was plagued by voices which implied that she would have sexual relations with her employer, pose nude for him, and so on. When she became so upset that she had to stop working, a friend referred her to a local clinic for treatment.

For nine months she received psychotherapy as an outpatient and became increasingly disturbed. She identified her therapist with her former employer, incorporated him into a similar delusion, and refused to take any medication. After assaulting a stranger she was hospitalized at a county psychiatric hospital, diagnosed as a paranoid schizophrenic, and 10 days later was transferred to the special unit for the deaf.

The marked paranoid ideation disappeared rapidly in the structured and unpressured hospital environment, and for most of her stay she showed a minimum of overt psychotic symptoms. In an occasional temper tantrum she would smash the table and complain that she had been hospitalized without reason, but generally she was responsible and reluctantly cooperative. She grudgingly accepted medication in high dosages, and meanwhile undertook the role of a stern mother with several younger patients. In addition to attending group and individual psychotherapy sessions, she was sent to typing class and given ground privileges. After a brief seven months of hospitalization she was considered sufficiently symptom-free to be released on convalescent status.

The rigidity of her personality made her an extremely difficult person to work with in a therapeutic relationship, and set limits on the kinds of therapy that could be utilized. Unable to tolerate the possibility that she may have contributed to her interpersonal problems, she held to the view that she was the suffering victim of others' unjust actions. Her need to deny the existence of her illness was so great that the therapist's attempts to help her face up to it always evoked either a blind defensive rage or a flareup of paranoid ideas.

With such a strong need to deny her illness, she always resented attending therapy sessions, and turned them into periods of harangue, lecture, or complaint, in which she controlled and thoroughly subdued the therapist. Assured of his submission, however, she could accept his medicine—or even advice—as a kind of tribute from a powerful vassal. After going on convalescent care, she often arrived late for appointments or tried to terminate the sessions before they were finished. Only under the circumstances outlined could she use the sessions constructively, and obviously no insight was achieved. Nonetheless, as long as her control was unquestioned she seemed to gain some support from the relationship with her powerful but subservient ally. With gratitude, she allowed him to relieve some external sources of pressure by arranging for her part-time employment as a housekeeper and for the Division of Vocational Rehabilitation to finance her training for future full-time employment. Interestingly enough, with the therapist's ear available for complaints she was easier in her demands and relationships with others. Though her adjustment after leaving the hospital was marginal, she was able to attend school for some eight months where they were pleased with her progress in typing and punch card training.

Case 2: V. O. was a 28-year-old woman, transferred to the special unit from another hospital where she had stayed for a month after an attempted suicide. Congenitally deaf, she was the older of two children raised in lower middle-class circumstances. Her father never accepted her deafness and had detached himself from her completely; her mother, on the other hand, had been extraordinarily devoted. When the patient was 14 the mother died, and a maternal aunt took over her position. The aunt was strict, punitive, and given to fits of anger; she was not above throwing a knife at the patient when crossed. Little protection was offered by the father or uncle.

Despite her severe deafness and only average intellectual gifts, the patient did remarkably well at school. She received an award for excellence on completing her elementary training, and continued as an honor roll student at a high school for hearing pupils. In her junior year she met a deaf boy, dated steadily, became pregnant, and eloped. Her family disowned her, but the husband's parents provided the young couple with a place to live in, and other assistance.

Over the next nine years, life was relatively tranquil. The patient recovered spontaneously from mild depressive bouts after the birth of her first child, who was deaf, and the termination of a later pregnancy in a stillbirth. She tolerated a third pregnancy well, and gave birth to a hearing son.

Family and child-rearing pressures increased over the next year. The patient had some menstrual irregularity for a few months, and was treated with injections. When menstruation was induced she believed that she had been aborted and became depressed. A series of dreams instructed her to save her husband and children from becoming blind or crippled by dying herself. Her depression increased and finally, in a state of agitation, she slashed her wrists and drank some iodine.

She was hospitalized for a month, made no improvement, and was transferred to the special unit for the deaf. On admission she cried a great deal, and expressed feelings that she was an evil person. However, she was easily distracted from her tears into a flat recitation of her delusion that she must divorce her husband to save him and their children from an avenging God. She was diagnosed as schizophrenic, mixed type, and treatment began. She was seen in individual and group therapy and integrated into the general ward program. During her 11 months of hospitalization a variety of psychotropic drugs were used until an effective combination was found. In the later months she attended typing class, and made a number of home visits of increasing duration. She was placed on convalescent care, and visited the outpatient department weekly where she saw the same therapist who treated her in the hospital.

The patient was unusual in her ability to make use of an insightful psychotherapy. She was relatively young, and emotionally and verbally apt. She was one of the few deaf and psychotic patients who became keenly aware of—and accepted—the fact that she had been ill. While this insight itself produced anxiety, it served to motivate her to use the therapy more, and to gain an understanding of the internal pressures which had contributed to her illness. With help she was able to experience the anger towards her family implicit in her delusion that she must die to protect them, and the guilt which paralyzed her. She recognized this conflict as a source of feeling of unworthiness, helplessness, and agitation. She came to feel how her attempted suicide grew out of her rage and guilty helplessness as an expression of expiation, frustration, and surrender. As these feelings were expressed and explored, the therapist also worked to help her find realistic sources of gratification. She was comforted by the recognition that it was permissible to resent her husband and children at times, and that there could be relief in expressing it occasionally. Thus freed, she was first able to enjoy a sense of importance, with room for expression in her role as homemaker and mother. Her other real and positive qualities were also emphasized, and she was encouraged to take a correspondence course that led to a high school equivalency diploma—something she had always wanted. With the therapist's support she resumed relationships with intellectually interesting friends, whom she had stopped seeing since her husband had shown little interest in them. As a woman for whom scholarship had been quite important, she found reassurance in sensing herself as "intelligent."

The doctor also maintained a close contact with the patient's relatives. Her husband was a good provider, and turned out to be genuinely interested and cooperative throughout. Other family members created considerable pressures on the patient in one way or another and had to be dealt with. Her father, particularly, vacillated between guilty overconcern and cold disinterest, and required considerable help to achieve a more balanced stance. Her mother-in-law, on the other hand, learned to be less meddlesome while maintaining a healthy degree of involvement.

Few of the deaf schizophrenic patients were as intelligent or fluent (manually or verbally) as the two presented here, or had even so propitious a set of outside circumstances to which to return. Work in the in-hospital teaching program was a requisite in the treatment of many. Among patients of lower intelligence or with more widespread disintegration, the group support found on the ward and the pressures of group therapy played at least as important a role in modifying attitudes as the one-to-one work in individual treatment. For example, one patient's belief that a black ghost she had "seen" had caused all her misfortune was eroded only by group influence, her doctor having made little headway on the issue (cf Chapter 8). The same patient typified a number of problems that existed among the group of deaf schizophrenics with regard to the quality of her background and the arrangements awaiting her return to the community. She was the sixth of seven poor children, and had left school with few accomplishments at the age of 17 when she was discovered to be pregnant. A marriage to another man had failed, and she had been hospitalized for neglect of her children while living in a common-law relationship with still a third man. It was this man to whom she returned when released on convalescent care, only to have the staff discover that he was psychotic himself, exciting the patient with his own persecutory delusions and writing long letters of complaint to the governor and other important persons. Treatment for him was included in the aftercare program for the patient and a measure of stability was maintained.

What has been said of the schizophrenic cases held true for the treatment of other psychotic forms of disturbance as well. The emphasis, however, varied between diagnostic groups and from case to case. Thus, while most patients required medication of some sort, those who were agitated schizophrenics would receive different pharmacologic agents than those diagnosed as involutional depressives or as suffering from adolescent behavior disorders. In point of fact, true psychotic depressions were extremely rare in the cases seen over the course of this project, supporting the contention derived from the previous study that the signs and symptoms of retarded depression are unusual among the deaf (6).

Primitive Personality

There were some deaf patients who did not fit into any of the conventional diagnostic categories, yet evinced particularly severe difficulties in adjustment. These patients, suffering from simple but widespread deficiencies in psychological growth and maturation which become more complicated as time goes on, had arrived by different roads to a state of severe inexperience and immaturity. The picture they presented resembled in some ways those rare children described in the literature who were abandoned as infants and found living with animals. For such patients the earlier project devised the label "primitive personality" (8, 9). Their management usually started with training to improve communication, and continued through instruction in basic grammar and arithmetic to the finer aspects of learning to develop interpersonal relationships. Social behavior had to be taught in some cases from first principles, such as learning to say "thank you" with a smile, taking care not to annoy others with loud noises, and avoiding ugly grimaces or direct attacks. Self-consciousness or pride in personal appearance had to be inculcated and, step by step, the importance of the rules of behavior for successful life outside the hospital.

Individual therapy served a twofold purpose for these patients. On the one hand, it was usually supportive, didactic, and directive. Equally as important, it provided a meaningful relationship, perhaps the first in a patient's life, which could serve to bridge the gap to other cooperative friendships. Or, as one of the following cases will show, it offered an opportunity to replace an important relationship that was warped with one that was more firmly oriented to reality. The group therapy, and even the total ward milieu, extended these efforts and served as a forum for supervised trial and error in putting to use what had been learned. Lavish in praise and severe in criticism, the group was also the nexus out of which hesitant friendships budded and grew.

Further help accrued from the efforts of the volunteer organizations developed by or affiliated with the project. By providing plays, parties, and educational programs, and taking an occasional patient on an outing, the deaf workers from these organizations helped patients to develop social skills and expand their practice beyond the hospital walls.

The next two case histories illustrate alternative paths for the development of this primitive kind of disturbance and the slow, uncertain progress possible under the tutelage of the staff.

Case 3: K. O., a congenitally deaf girl of 20, was the much-awaited child of a psychotic mother and a near-psychotic father. Born to the couple after a barren 11 years, the patient suffered a birth injury with a resultant torticollis (bent neck). The mother had a brief psychotic episode soon after delivery.

The parents were delighted with their baby and completely overlooked the deformity, claiming that they could correct it by proper placement of a pillow. The same denial was extended to the question of her deafness which was subsequently diagnosed by their physician. The parents insisted that she go to a regular school, despite repeated attempts by the school authorities to persuade them of the need for special help. When the patient failed to learn, they withdrew her altogether and made futile efforts to teach her lip reading themselves. K. had no friends or playmates and for the most part was kept in or near her parents' isolated home.

When she was 14 years of age, the patient's father died, and her mother became even more seclusive. The patient became depressed and started to have temper tantrums, in which she would scream wildly and express hostility toward inanimate objects. The mother met this problem by tying her to the furniture. Over the next five years the mother's psychotic process became more and more overt and culminated in her removal to a state hospital in an acutely hallucinating and delusional state. With no place to go, and wholly dependent on her mother, the patient clung to her mother and had to be admitted to the same hospital.

She was soon transferred to the special unit, where clinical observation led to the conclusion that she was not psychotic and probably had an average though untapped intellectual potential. No further diagnosis was possible.

The transfer constituted her first real separation from her mother. On arrival she could neither talk, read lips, or sign, communicating only by special gestures that had been understandable to her mother but to no one else. She was depressed, sluggish in response, slow in everything she did, and easily discouraged by the slightest difficulty. The initial program for her management stressed intensive efforts to improve her communication skill and to teach her some

English and arithmetic. She was also allotted some light activity in occupational therapy, in which she participated with incessant protest. Once she was engaged in the teaching program on the ward she proved to be a good learner, despite her reluctance. As her communication improved she benefited more and more from the individual and group psychotherapy sessions. Her participation in the latter gave her the first opportunity for social exposure and interaction. At first she would sit through the sessions passively without expressing herself in any way. If the group turned its attention to her she would become irritated, and often walked out of the room. Yet she continued to come regularly, almost in a ritual fashion. Then she gradually started sharing the mood of the group, smiling, laughing, or expressing sorrow as the occasion indicated. With improvement in her communication skill, she participated more and more actively, giving the group some fascinating details of her childhood experiences in the hearing school. After two years she arrived at a stage where, if given the opportunity, she would monopolize the group session with accounts of her life history; her stories often captivated the group's attention. In short, she grew into a young woman of some charm and pleasing manners. She continued, however, to be fearful of a life of her own without close guidance and support, and her unshaken and stereotyped insistence on wanting to live with her mother remained the greatest impediment in plans for further rehabilitation. Her ability to communicate was such that this could be made more and more the focus of individual therapy. Meanwhile, her mother, still a hospital patient elsewhere, continued to write her daughter meddling letters from a distance.

Case 4: V. B., a 26-year-old congenitally deaf woman, had lived a life of hostile rejections from her family, and of indifference or misunderstanding from the world at large. Born out of wedlock to a teenage mother, she had been immediately surrendered to the custody of her grandmother and great-grandmother. After caring for her for six months they handed her over to a foundling home, and she circulated in foster homes until the age of 10.

What happened between the ages of 10 and 16 was shrouded in mystery, for the mother consistently refused to discuss it with anyone—a measure of the hostility she retained towards the girl. The patient herself referred to these years with shame. Whatever else may have happened, she apparently received some intermittent schooling at residential schools for the deaf, from which she benefited very little in either general knowledge or facility in communication. She consistently showed interest in art work, however, and acquired a fair skill in sketching and painting.

At the age of 16, the patient was taken back to live with her mother who had married and had a young adopted daughter. She was reported to have adjusted poorly to her living situation with the stepfather and the adopted sister, and to have created much tension at home. At 18 she was brought to the pilot clinic for evaluation because of temper tantrums and insubordination to the mother. She was diagnosed as a case of behavior disorder and an attempt was made to intervene and ameliorate the family situation. The home picture deteriorated too rapidly, however, and the mother, regarding her as a threat to her marital accord, placed her in a residence for girls. She continued to display a severe behavior problem and was shortly hospitalized at a state hospital, whence she was transferred to the special unit.

Initially she was a bewildered and angry young woman, fluctuating between a cooperative and pleasant mood and one of extreme intransigence. Towards her mother she showed ambivalence, looking forward to her visits, expecting to be taken home and provided for, yet being unpleasant when her mother came. Much of this resentment was well founded, for the mother persisted in her cold attitude. She would often sit opposite the patient without speaking, and she never cooperated in explaining her daughter's past or in planning for her future. Finally, she stopped visiting and writing altogether.

Instruction in communication was stressed in the total program planned for this patient. She was also encouraged and coached in her painting, and the stiff and stereotyped qualities of her art productions improved as her personality expanded. The long-term goal of individual treatment was to wean her from her angry and fruitless expectations of her mother, replacing her hostile ambivalence with a healthy pride in being a capable young woman. In the group sessions her asocial behavior was a frequent topic of discussion and review. She slowly developed an appreciation for this interest in her affairs, and turned the corner after almost two years in the unit, with every effort reinforced in the group and individual treatment sessions. She started putting more feeling into her drawings and their lines showed increasing sensitivity. She began drawing from models, and her paintings became so popular with the patients and their relatives that she received commissions to paint for them. This recognition was an added booster and helped her to acquire greater efficiency in her work. She also improved appreciably in cooking and typing.

Volunteers were asked to take the patient for a day's outing in an attempt to restore her links with the world. They reported that she was extremely well behaved and pleasant. Finally, the patient was ready to leave the hospital provided some place could be found for her to live in. The mother had withdrawn all interest from her, so that it was necessary to tap other agencies in the community. The initial responses were hopeful and it was expected that a fairly stable arrangement would be made for her to live and work outside.

Social Maladjustments

The next case is at the opposite end of the spectrum from those already cited. Here the problem was not so much one of the patient's inability to communicate, but the failure of the surrounding world to perceive, understand, and respond to the messages encoded in his behavior. As a youth he was considered by the standards of a hearing world to be psychotic and incorrigible. He was hospitalized for years, but an overburdened staff, ill-equipped to recognize or evaluate potential for change in such a patient, paid little real attention to him as the years went by. Were it not for the establishment of the special unit and its team of roving doctors, there is no doubt that his story would have ended without any new beginning. Instead a good deal of personal suffering was relieved, and it was possible to interrupt the expenditure of thousands upon thousands of dollars for the unproductive maintenance of a potentially employable person. This type of case is rare, but not unique, accounting for two of the 50 patients treated treated so far.

Case 5: J. C., a 39-year-old white male, was transferred to the special unit at the request of the staff after 23 years of hospitalization which began when he was 16 years old. It was clear at the time of transfer that the hospital had become his way of life and a place of permanent sojourn. Both parents and a brother were occasionally alcoholic, but the family history was negative for more malignant forms of mental illness, and for deafness. The patient had become deaf from meningitis at about the age of six.

During his early years at school he had been described as pleasant and friendly. At the age of 13 he ran away after being transferred from one school to another. He was returned to the school of his choice, but shortly escaped again. Over the next year or so, this pattern of behavior became confirmed as he frequently ran away from home, from school, and even from some after-school jobs. His parents, who had little understanding of his problems, tolerated this behavior poorly and after a few abortive attempts to get help they arranged for his admission to a state hospital. He was diagnosed as having a psychosis due to organic brain disease and was treated for the most part as a candidate for custodial care.

While in the hospital he was described as an ideal patient, despite a large number of elopements and escapes. Sometimes during these escapades he got drunk and unruly, though it was never reported that he harmed anyone. On two occasions he traveled south, worked sporadically, and presented himself to the local hospital when out of money. At other times he returned to his hospital when he was ready after visiting local friends and relatives. An occasional home visit sponsored by the hospital failed to work out because of drunkenness, and over the years his family became even less interested in him.

Initial examination in the unit for the deaf revealed a personable man who communicated clearly through manual language and whose voice was also reasonably well preserved. He responded to questions freely, answering with relevance and reason, and no evidence of psychosis was immediately discernible.

In a matter of days he adjusted well to the ward. By dint of his affectionate concern for all and a rich fund of stories and anecdotes, he quickly assumed the role of elder brother to several less well integrated patients. He worked well, and in group sessions generously shared his opinion about a wide variety of subjects.

Intensive explorations confirmed the fact that no active psychotic process was present. What had been long regarded as psychotic fugue states (episodes of amnesic travel from which the patient would "awaken" in a distant place) were defined at last to be this deaf person's nonspecific way of expressing protest and resentment. In individual treatment he welcomed the chance to be understood, and poured his heart out.

Working closely with a number of social welfare agencies, the staff found a job which fitted the patients limited but expandable skills as revealed by testing. Within three months of his admission to the ward he was placed on convalescent care and employed. He was visited several times at his work, and he came to the clinic regularly for further supportive psychotherapy. He attended the unit's most recent Christmas party on the ward, bringing gifts for several of his friends, and he appeared to be quite happy.

Impulsive Disorder

Last to be presented are the case histories of a particular group of deaf patients among whom the problems of diagnosis, treatment, and outcome were especially puzzling. It has been noted elsewhere that the majority of deaf inpatients are admitted because of unruly, impulsive, sometimes bizarre behavior, regardless of the type of underlying illness (3, 66). The patients in this group are no exception in this regard, yet examinations in depth often fail to reveal pathology of psychotic extent. Their behavior continues to be erratic, sometimes antisocial, short-sighted, and without perseverance. In some ways such patients appear to be like the hearing psychopath, a conscienceless character, antisocial and impulsive, a swindler, petty thief, or the like. Yet the deaf patients are generally without guile or malice, and have at times a clear awareness of right and wrong. When crossed, they may quickly give way to violent temper tantrums, but otherwise they are openly friendly and eager to please. They differ from the more primitive group previously discussed in possessing many functions (including the ability to communicate) that the others lack. These functions are developed unevenly, with special weaknesses in the area of control. This type of case is common in the deaf, representing 12 percent of the inpatients treated on the special unit.

Case 6: L. F. is a 22-year-old white man, congenitally deaf and very short in stature. He was admitted to the special ward in January 1965, his first admission to a mental hospital. His father is also very short, but there was no family history of deafness. At the school for the deaf which the patient attended from age 5 to 17 his behavior had been characterized as indifferent and defiant, and there was some question that he might be mentally retarded. His aggressive behavior led finally to his discharge. After a brief stint in another school, he quit for good.

For the next two years he was involved repeatedly with the police for petty thievery and destruction of property. Each time he was apprehended he would freely admit to his offense. Indeed, he was so cooperative that he would admit to offenses he could not possibly have committed, and then vow in stalwart fashion that he knew he had done wrong but would never do so again. In 1962 he was placed in a correctional institution. After two years he was released on parole, which he promptly violated. A short time later arrangements were made for hospitalization.

On the ward, he was generally cooperative and pleasant. His physical examination was negative but for his height, and biochemical and endocrinological findings were normal. Though genial and open, he was prone to emotional lability, with impulsive outbursts of anger and defiance precipitated by minor frustrations. He was always well-oriented and well-informed, but his general intellectual level was low normal, and his ability for abstract thinking notably constricted. His diagnosis was emotionally unstable personality.

Case 7: L. A. is a 20-year-old white girl, admitted to the special ward in August 1963. Six months earlier she had been placed in a foster home after her expulsion from a school for the deaf where she had been telling many stories about sexual assaults. It was not known whether these stories were true or fabricated. Her behavior in the school, and initially in the home, had been characterized as "cyclic," going from sweet docility to stubbornness, temper tantrums, and provocative sexual misbehavior. The foster mother maintained a great interest and loving discipline, and in response to this kind of care the patient had seemed to improve greatly.

A month before the patient was transferred to the hospital, her older sister visited the home, bringing her newborn infant, born out of wedlock. The patient made a great fuss over the child and became quite excited. From that time on her behavior grew worse. Her sexual preoccupation increased, and she seemed to seek out contacts deliberately as if trying by any means available to have a baby of her own. The night before admission she returned after several hours in the woods with an older man, dishevelled and distraught. She was uncontrollable and agitated, the police were called and she was taken to the hospital.

The patient had spent most of her life in foster homes. Both parents were alcoholics, the father denied paternity of her birth, and the mother allegedly had run a house of prostitution. Her deafness, apparently congenital, was first diagnosed at seven months, by which time the patient was virtually on her own. The pattern for foster parents was always the same; initial delight with her affection, obedience, and intelligence gradually giving way to angry rejection as her provocativeness and demands for love became more and more insupportable. As she grew older, her indiscriminate sexual impulsiveness quickly elicited this kind of response.

In the hospital, her general physical examination was negative. She was usually neat and well-groomed. With the doctors she was friendly but shy; with the ward attendants and male patients more direct and seductive. She was easily embarrassed, and became blushingly pained and evasive to all questions concerning her sexual behavior. She was emotionally responsive, but at the slightest frustration acted impulsively or had a tantrum. Her tests revealed at least average intelligence, though her insight and judgement were very limited. Her diagnosis was emotionally unstable personality.

After 15 months of treatment she was considered to be ready for convalescent placement. Following a number of failures to find a suitable place for her, her mother whom she had not seen for over 20 years was located. Surprisingly, the mother desired to have the patient live with her. The patient was discharged on convalescent care to reside with her mother. She worked as a cleaning girl and dishwasher, and apparently made a limited but satisfactory adjustment.

Case 8: Z. B. is a 22-year-old deaf Puerto Rican female admitted to the special ward in December 1963. She had been found by the police, agitated and confused, in a hotel with a boy, and was taken to a city hospital. On admission there she seemed inappropriate in affect and showed some paranoid ideation. Her diagnosis on transfer was psychosis with mental deficiency.

Born in Puerto Rico, an only child and congenitally deaf, she had come to this country at the age of 10. She attended school for the deaf in Puerto Rico and in the United States, where she maintained her grade level, although with some difficulty. Here parents were divorced three years prior to her admission, and she had been living with her father. Her difficulties in adjustment began at the age of 14 and included impulsive behavior, irresponsible lying, and staying out late with boys. Over the three years preceding admission, her father found her increasingly difficult to control; she would either deny responsibility, or promise to be good and merrily go on her way.

In the hospital her physical examination was negative. Mental status examination revealed dull-normal intelligence and underdeveloped judgement, particularly in social situations. She was happy, eager to communicate by sign language and finger spelling, and openly friendly, but quick to become cross and sulky. No psychotic mental content could be elicited. The hospital course was relatively peaceful. After a period of investigation and individual psychotherapy her diagnosis was changed to emotionally unstable personality in a person with borderline intelligence. Continued individual and group therapy was directed at the development of responsibility and judgment and some internalized controls to guide her social behavior. She was discharged after 15 months to be followed in the clinic, where all indications were that she was working steadily and making a fairly good adjustment.

Psychiatric observations and psychological examinations in all three of these cases revealed personality structures that were unevenly developed and poorly integrated. It often appeared that perceptions were vague and ill-defined, and that capacities for adapting to new situations and structuring new experiences were very limited. Internalized controls were minimal, and impulsivity predominant. Critical self-awareness was constricted as was the capacity for empathy with others. Anxiety and tensions appeared to demand quick discharge through action, often inappropriate to the situation. I.Q.'s of the patients were in the average or low average range.

The body of general psychiatric knowledge confirms the unit's experience in emphasizing the uncertainties of treatment for such patients. With a scarcity of studies on the impulsive type of character, there is even confusion on the underlying disease entity. Michaels has suggested that impulse disorders represent a separate class of illness, with the impulsive psychopath being one extreme within the category (55). Others affirm that individuals with poor impulse control are in a borderline area, where the differentiation between neurotic and psychotic is vague and often undefinable. On the basis of clinical and neurophysiological observations, some theoretical correlations have been drawn between the impulsive character, traumatic neurosis, epilepsy, and hysteria, with immaturity in its broad sense being their common denominator (35, 54, 56). The psychoanalytic writings on persons with extremely impulsive behavior emphasize a malformed superego (conscience) and an excessive degree of narcissism (38). Others describe a primary orientation to senses and things, so that perceptions, concreteness, and action take precedence over conception and abstraction (14, 49, 58).

There is no assurance, of course, that deaf patients with impulsive behavior are comparable with the hearing subjects in the studies mentioned. As an externally imposed limitation on early affective interchange and the development of symbol formation, abstract capacities, and social awareness, early total deafness might be expected to have enduring effects on the formation of character (2, 6, 49, 59). Coupled with other individual stresses, these limitations could lead to shortsighted, inappropriate, and impulsive behavior on a basis quite different from that which underlies such problems in the hearing.

Experience in the unit indicates that treatment of deaf patients in this category demands unusual time and perseverance, and there is never certainty about the outcome. Often continued stay in the hospital is necessary to protect both the patient and society, and to ensure sufficient control of the patient for the implementation of a treatment program. Individual psychotherapy, while necessary, seemed less fruitful in such cases than group therapy, where peer pressure acts towards control and conformity and supports the growth of social awareness and individual identity within the group.

With limited goals, and emphasis on training and the establishment of a modicum of internalized controls, a number of such patients were discharged and took jobs in the community. They seemed to hold their own, though the hold was sometimes tenuous and they required continued supportive contact with the project's staff. Given time, and further research and experimentation with treatment methods, limits of change for this most challenging group of patients may be further tested and defined.

Drugs and Somatic Treatment

The introduction of chlopromazine in 1952 heralded a rapid expansion of efforts to develop symptom-specific or disease-specific pharmacologic agents. Over the succeeding years, the value of a number of chemotherapeutic adjuncts was demonstrated. For a patient, enjoyment of a more positive life experience may be directly related to the extent to which a particular tranquilizer, anti-depressant, "energizer", or stimulant may impede or reverse disorganizing processes. Tranquilization or reduction of specific target symptoms (e.g., depression, agitation, hallucinations) may also be associated with the emergence of positive changes in motor, perceptual, intellectual, and social performance.

The usefulness of such medication in the treatment of deaf mental patients has never been in question. Here, as with other forms of treatment, the problems in making equal services available were those of accurate evaluation and diagnosis, upon which proper prescription must be based. When these problems were overcome, the medications could be used appropriately, as in hearing patients. Their proper utilization was of comparable value among deaf patients in simplifying management procedures and facilitating psychiatric treatment.

Compounds of the phenothiazine series were primarily prescribed for the schizophrenic patients. They were helpful in relieving tension, restlessness, noisiness, agitation, assaultiveness, and low frustration tolerance. These compounds supposedly alter the psychological defenses of disturbed patients qualitatively, but their specific biological effects are still a matter of controversy (78). Controversy also exists about the signs of extrapyramidal system disturbance (muscle rigidity or tremor) which may be induced by most of these drugs; some clinicians consider such symptoms to be undesirable, while others take them to indicate an adequate level of medication, and as the *sine qua non* for predicting improvement (13). Electroshock treatment was used with some success in two psychotic patients with extreme withdrawal or catatonic stupor or agitation.

Special problems arose in medicating the impulsive patients previously described as unstable personalities. Hearing delinquents and problem children have been shown to have electroencephalographic abnormalities of brain function in a relatively high percentage of cases. Most such patients have no clinically evident convulsive disorder and their gross neurological examinations are negative (18); yet they show a variety of psychological distortions, lags in maturation, and disruptions in personality development. Favorable results have been reported by a number of workers treating such patients with anticonvulsant drugs and antihistamine derivatives (18). For neurotic behavior patterns in adolescents, and even more so in children, the amphetamines have been found helpful (19). In such cases the relief from tension and sexual drives permits the establishment of better modes of relationships in a peer group, and children do not generally lose their appetite or become stimulated by drugs in this series.

Six young or late adolescent deaf patients on the ward with unstable conduct showed some electroencephalographic evidence of brain damage, while three patients manifested primary disturbances of behavior without accompanying electrocortical changes. A favorable effect was obtained in some of both types of patients, using a combination of amphetamine and an antihistamine. From the small sample of patients available at the time of this report, however, no firm conclusions could be drawn.

Chapter 8

DEVELOPMENT AND OPERATION OF GROUP THERAPY

Isolation, a frustrating experience for anyone, is an ever-present reality in the life of most deaf persons. When the situation is compounded by mental illness, where two-way communication is so important in relieving the tormented mind, alienation and loneliness can amount to a life sentence.

Primarily to lift the curtain of isolation, the inpatient facilities were designed as a therapeutic community for the mentally ill deaf. The ward milieu was built to encourage communication. All the staff could converse in manual language; there were recreational and pre-vocational facilities, with personnel to offer guidance in their use; interplay across age groups was present; and social mingling between the sexes was encouraged. In addition, there were medical specialists who viewed the patient in his totality and attempted to remedy his specific psycho-social difficulties in adjustment.

Some History of Group Therapy

The philosophy underlying this structure is based on the idea that social milieu and group pressures are basic factors in shaping patterns of behavioral response. Individual, subjective experience varies from birth with different constellations of social influence. Geographical locale, family, social class, and the individual's genetic make-up are important in structuring experiences. There is a growing appreciation that small groups (epitomized in the family, but also in gangs, clubs, and segments of subcultures) have profound influence on molding personality. This awareness, coupled with an increasing demand for psychotherapeutic help, has led to the rapid development and acceptance of group treatment in the last few decades (81).

While the mutual reverberations within small groups have been casually recognized since the beginnings of history, the use of the group as a formal treatment technique originated with Mesmer's group hypnotic sessions in the 1700's. Present-day group psychotherapy dates from the work of Pratt, a Boston internist who organized groups of tuberculosis patients into classroom-type settings in 1905 (30).

During the last 60 years group psychotherapy has become a burgeoning field with a number of controversial issues and diversities of opinion. One school of thought prefers to structure group therapy in a laissez-faire fashion in which the group directs itself (37, 63). Another takes the more analytic approach in which the figure of the therapist is central and in which attitudes to and about him are stressed (81, 82). Still another favors the most directive efforts, in which the group leader directs discussion towards problems that he selects or perceives to exist among the group members (63, 95). In general, among hospitalized patients some combination of the latter two philosophies has been found most useful (44)*. What follows is a description of experiences encountered in the unit for the deaf, the steps and missteps as a program of group therapy evolved for the heterogeneous group of deaf mental patients who were hospitalized there.

Group Therapy in the Ward for the Deaf

In a sense, group therapy began as soon as a patient entered the ward. With the recognition that all members of the unit could communicate with him in sign language, and he with them, the shroud of isolation was partially dissolved. Able to make himself understood, perhaps for the first time in years, the patient's interest in reality was often heightened and some of his tensions seemed to decrease. Even some of the most agitated patients soon began to relax, feel at home, and make tentative efforts to communicate with others. The improvement in general atmosphere thus provided a favorable beginning to the process of the patient's ultimate social and psychological rehabilitation.

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* While numerous publications on these practices often reflect the author's personal psychology and preference, a few detached reviews of the various rationales and techniques are available. The interested reader is referred to those of Frank or Klapman (29, 30, 43, 44). In this connection the contributions of Piaget, the scientist of child development who studied how the child learns the rules of the game in socialization, are also important.

Formal group psychotherapy was initiated on a once-a-week basis four months after the ward was opened.* At that time the patients were exclusively female. The staff tried different methods of conducting the sessions, since there were no well-formulated approaches applicable to the deaf. The first attempts to interpret the individual's problems as manifested in the group and to bring out the motivations behind temper tantrums and sulky expressions of anger were handicapped because the therapist conducting the sessions had limited experience with the intricacies of communication and interaction in a deaf group. Many times one of the patients would assume the role of interpreter, and often of mediator.

For several weeks, the group could not be budged from concrete day-to-day problems of living in the ward. Each patient tended to project his problems as if they stemmed from the general environment, and there was little interest or critical facility in considering the expressions of other patients. Most members of the group completely denied their illness, or tended to cast blame on whatever environmental factors happened to be available.

This state of affairs improved as the therapist was able to take a more active role in developing an awareness among the patients that temper tantrums and other impulsive angry acts were their ways of expressing non-specific tensions.

After three months of this work, the group therapy sessions were increased to twice weekly at the patients' own request. By this time all patients were relatively comfortable in the group setting. There was a tendency on the part of several patients to strive to develop a dependent relationship with the therapist. This was manifested often in simple and symbolic behavior, such as a patient sitting next to the therapist, touching him during the session, clamoring for his attention or speaking only to him whether or not it interrupted someone else. In an effort to promote a greater independence, the therapist shifted briefly to a more Rogerian concept of therapy, assuming a passive role and reflecting only the patients' own productions. Explaining some of his reasons for withdrawing from active participation, he waited to assist the group in developing its own structure and lines of interest. The result was a number of disjointed sessions in which the patients sat perplexed, occasionally expressing fragmentary ideas, tending to have less and less contact with the concerns of the others. This failure served to emphasize to the staff that a deaf group needs a strong though flexible leadership.

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* For detailed protocols of representative group sessions, see Appendix D.

Arrival of Male Patients

With the arrival of the first male patients in January 1964, a change in the group could be observed. Awareness between the sexes developed even in the most isolated patients and led quickly to a greater awareness and interest in others of the same sex. This interest was evidenced by an increased concern with grooming, greater group cohesiveness, a livelier interchange, and gradual progress toward the recognition of illness and change in each other.

Some patients tried to identify or compete with the therapist, even at times assuming his role in the group. This development prompted an experiment in which certain patients were assigned to conduct the meetings under the supervision of the psychiatrist. It was hoped that such an arrangement would improve the patients' awareness of their immediate environment, since they would be actively involved in creating it, and that this increased awareness might lead to the development of greater self-reliance. Some of the questions insistently and repetitively directed to the therapist became obviously absurd when addressed to the conducting patient, and soon the questions tended to assume a more realistic pattern. For example, the question of discharge soon became naturally related to patients' improvement instead of appearing to be an arbitrary decision of the doctor. For his own part, the therapist could observe the group more easily when partially relieved of its direction, and devote himself to understanding and interpreting the actions of its members.

Experiment in Self-Government

A few months later, an experiment in ward government was tried. This move was designed to further enhance the decision-making role of the group, and to encourage the patients to develop more critical, reality-oriented judgments of themselves and each other. In this new ward organization, responsibilities and rights were apportioned to the patients, who evaluated themselves and each other and prepared suggestions for awarding or curtailing hospital privileges. In addition, a group of three patients was elected to settle issues and administer judgment in specific cases, subject to approval by the staff.

In the beginning, the government functioned promisingly well, taking up such matters as improving communication by emphasis on learning the sign language, encouraging cooperation with the medical staff, fostering mutual aid, and motivating the patients to work harder and better toward their improvement. A recommendation by the government led to curtailment of the privileges of three patients who performed poorly in the rehabilitation program.

Soon, however, some of the better-integrated patients were forming cliques which excluded the more disturbed patients and restricted mutual aid only to clique members. Then a strong-willed, young psychopathic patient took over the presidency in a coup d'etat by intimidating the rest of the patients and influencing their votes. He began to terrorize all the other patients into submission to his ideas of hard work, a rigid routine, and deference to himself, the leader. Refusals or disrespect were met with physical threats or beatings. Most of the patients were not mature enough, nor their ties to each other and their integration cohesive enough, to counteract the situation effectively, and in this atmosphere the short-lived ward government had to be suspended.

Development of Dynamic Group Therapy

After a year and a half of experimentation, the format of the group therapy sessions finally evolved. Meetings were increased to three times a week, again at the request of the patients. In at least one meeting each week one or two patients were given the role of discussion leader. The therapist was participant or leader, guiding the discussion flexibly and confining himself to interpretive comments as he allowed it to unfold, or holding the group to settle its own issues if the situation so demanded.

In this context, the group developed an awareness of its purpose, and the simple ground rules were explained to newcomers by its members. As a result, questions of grooming and self-care seldom arose (except in regard to enhancing beauty), discussion was animated but orderly, ward rules obeyed and the therapist was no longer nagged with questions of privilege and discharge.

The influence of the group widened as experiences in group interaction sharpened both the social perception of individual patients and their emotional responses to each other. A semblance of a decision-making body was retained when the group suggested certain jobs as suitable for different individuals, and discussed the reasons for their choice. The patients tried to understand changes in the mental state of other members and freely commented on whether ward privileges should be granted or withheld.

Suggestions sometimes were remarkably appropriate. A non-psychotic patient, for instance, with severe problems in behavior, had reached a plateau after some improvement. After a discussion, the group concluded that she kept to herself too much, and that she sulked because she did not feel friendly toward anyone. The group appointed one of the more mature patients to sit and talk with her so that she might appreciate the benefits of communicating with others and learn to enjoy social interchange. The staff observed many such instances when group pressures and mutual aid helped to change attitudes and reduce emotional constriction.

It became evident to both staff and patients that more active participation in the group indicated a better prognosis. In contrast, those patients who persistently avoided group sessions were often labeled "mentally ill" by the group. Some patients spontaneously emerged with multiple roles, as moderators, as liaison agents between the therapist and the group, and as models for identification. This phenomenon became self-perpetuating, since these patients generally moved out of the ward early. Their places were filled by others who assumed leadership roles as they improved.

Deaf patients came to the group sessions not only with their current symptoms but with questions and doubts which may have waited years for answers or for an understanding ear. They often used the sessions for fact-finding purposes. To illustrate, two patients escaped from the hospital and were apprehended by the police in only a few hours. When discussing the episode the next day, the group expressed great curiosity about how the police could perform such a feat! The more knowledgeable members explained that since a network of communications alerts the police in a matter of moments, it is unlikely that any patient, more so a deaf one, could escape successfully. This piece of information was very revealing to most patients and the remainder of the session was spent in further mutually educative exchanges.

Improvement of the patients and recommendations for home visits or discharges were always lively topics for group discussion because these subjects afforded opportunities for patients to anticipate and clarify conflicts that might arise in their relationships with others in society. The problems most often introduced in this context concerned attitudes and reactions to work situations outside the hospital. The successes and failures of recently discharged patients, who frequently returned to visit their friends and former associates in the hospital, were of great interest to members of the group, who commented fully and strove with interest and remarkable diligence to understand them.

Psychotic Symptoms and Group Process

Perhaps because the deaf patients were pent up from lack of communication over the years, they evinced a great need for emotional catharsis. Frequently a patient repeatedly expressed old grievances until group pressures led him to relinquish them. Sometimes a combination of catharsis, pressure from trusted sources, and perhaps the substitution of real interpersonal bonds led patients to alter the way they viewed their own delusions or hallucinations. A patient was often reluctant at first to relate his delusional thoughts, but once he began the process it was amazing to see how far the ball rolled. Initially other patients were very interested, uncritical, and credulous and a thorough exploration of the delusion usually followed. Gradually, uninhibited criticisms and disbelief were freely expressed. The group discussed and compared the delusions of different patients, more and more as stories rather than realities. The therapist attempted to guide the discussion in such a way that a process of intellectualization would displace tensions and anxiety. The patient whose delusions were being debated often acted out his feelings by crying or angry denunciations, and these were permitted to a point short of violence. The therapist kept as much in the background as possible, intervening to maintain law and order or to prevent the discussion from becoming stagnant.

It appeared that this kind of group struggle, disbelief, and interaction reduced some patients' emotional involvement and reactivity to their delusions even though the delusional thoughts remained unshaken. For example, a young female patient became tense and frightened as she related the story of the ghost she saw, whom she held responsible for all her misfortunes. At first, the group listened with rapt attention but as the story unfolded its attitude grew skeptical and gradually the patient was confronted with a remarkably candid cross-examination. At first she deeply resented their disbelief. Then she began to answer their questions in a more relaxed way. After several sessions devoted to her delusion and those of other patients, she took her own story more lightly and was able to talk about her ghost with humor rather than with panic and fear.

Transference Reactions

The phenomena of transference and multiple transference, where childhood attitudes and feelings are played out inappropriately in present relationships, are as common in a deaf group as in any other. However, these patients tended to shed all subtleties, expressing their feelings unmistakably, repetitively, and in an exaggerated fashion, frequently capping their hostility toward the group by walking out in a huff. Sometimes a patient would accuse other members of the group, or the therapist, of being "nosey". As noted earlier, positive or dependent transference was often expressed by sitting within touching distance of another patient or the therapist, or by gifts. Similar behavior has been reported in the treatment of other psychotic patients. However, its widespread occurrence in the deaf patients, especially among non-psychotics, suggests that deaf persons with mental illness may be qualitatively different in this way. The possible reasons for this have been touched on elsewhere, and may have to do with a tendency towards emotional expression through action, a paucity of available higher-level symbolic abstractions, and other aspects of immaturity (6).

To prevent a flare-up of the patient's defense mechanisms, interpretations of these transference situations were deliberately slow, and the therapist always attempted to guide other members of the group to come up with observations on the situation. Technical terms such as *transference* were of course carefully avoided because they only confuse the patient further and block communication.

Use of Dreams in Group Therapy

Dreams were brought up occasionally in the group sessions, and were helpful in alerting the therapist toward that conflict which preoccupied a given patient. While dreams may be interpretable with selected neurotic patients in individual treatment (67), their fruitful use with a heterogeneous group of very ill deaf patients may be severely limited. This is because meaningful interpretation of dreams demands that the patient be interested, that he be capable of feeling the continuity of emotions in past and present, and that he possess a high level of capacity to abstract, ability to associate, and an intuitive sense of the symbolic representation of emotions and events.

Relation of Group to Individual Therapy

Group and individual sessions cross-fertilized each other. Feelings that first came to the surface in the group were sometimes taken up and elaborated in individual sessions. With the patient's permission, material from the one-to-one meetings was sometimes referred to the group for discussion and opinion. Among these severely disturbed, multiple-handicapped hospitalized persons, the capacity for insightful therapy of much depth is very limited; few patients if any can be expected to integrate a meaningful understanding of the emotional roots of their problems with an understanding of current behavior, and so develop what might be called a reconstructed personality. Most interpretations, therefore, whether in the transference or other areas, were limited to emphasizing (or interpreting in a limited way) present warps in perception or behavior as related to the current reality. In this connection, the consensual validation of reality by the group, in contrast with the perception of a given patient, often exerted more cogent pressure than the single opinion of the therapist. Since the group shared many misconceptions by virtue of the disorganization in the personalities of its members, it was imperative to select carefully those topics which were brought from the individual sessions to the group.

The group showed a noteworthy tolerance for the behavior of its members under these pressures. When first confronted with the group's disagreement about a delusion or other personally important misconstructions, a patient might denounce the others and storm from the room. He soon realized that the group continued to function without him, and often he sensed a loss in no longer belonging. When the self-exiled patient returned he was usually accepted quietly, with neither jibes nor jokes, and allowed to pick up where he left off. Nonetheless, future confrontations were not avoided, and the whole process might be repeated several times. As previously noted, patients seemed to recognize that most of those discharged from the hospital were active participants in the group. Perhaps they were dimly aware that in the group lay the foundations of a social existence which is at once demanding and rewarding.

It was obvious that the group sessions would highlight for work in individual treatment those aspects of the patients' difficulties in adjustment that come to the fore in social interactions. On a more subtle level, the interchanges often alerted the therapist to emergent and sometimes dangerous trends, and provided an insight into their motivational fabric. To illustrate, a young man with a history of several attempts at suicide made a statement on the advantages of suicide as a method for achieving peace. A 23-year-old girl who had apparently been making some improvement suddenly agreed with enthusiasm. The group therapist reported the interchange to the patient's psychiatrist, who in subsequent individual sessions was enabled to confirm the fact of her growing agitation and sense of helplessness. Without doubt, his prompt exploration provided a decompression valve and allowed the exploration of feelings which, if left to build up, could only have led the patient to self-harm.

Results of Group Therapy

In summary, group therapy for deaf inpatients was demonstrated to be feasible and valuable. To make it work required firm but flexible leadership, an alertness to trends of feeling of the individual and the group, and a respect for the conceptual and emotional limitations imposed by the multiple handicaps of the patients. When properly used, group therapy was found to enrich concurrent individual treatment and serve as a vehicle for broadening general experience and learning to function in a society in microcosm. Perhaps of more importance, in the group experience the patients were able to yield some of their distorted perceptions for the sake of the good opinion of their peers. A sense of group identity slowly developed and with it came the first empathic interest in others ever experienced by many of these estranged, conceptually limited, and personally inexperienced individuals. The therapist had to possess patience and resourcefulness, and strive to create concrete situations which would extend to the entire group the scope of an individual's feeling and concern. Although this approach required time, effort, and dedication, its rewards were undeniable.

Extension of Group Therapy to Relatives

Responsible relatives with an interest in the patient—usually parents—have borne much of the strain of the patient's handicaps, whether or not they are deaf themselves. In their own communication of feelings and responses, they have often contributed in part to the final picture embodied in the patient's presentation. As an attempt to unravel the highly personalized, at times distorted communication within the family, the staff of the project initiated group sessions with the families and relatives of patients, and these were found to be very useful. It was obvious that these meetings, held with and without the patient, filled a much-neglected requirement for sound rehabilitation of the mentally ill, deaf individual. For the staff the sessions invariably opened up a reservoir of background information. and demonstrated nuances in relationships that would otherwise have remained obscured. Moreover, they afforded opportunities to understand the unique family language which develops between hearing parents and their deaf child, with its particular messages and omissions. The parents got the chance to express their own hurts, guilt, and confusion, and to come to feel they were of help nonetheless. Through the doctor's view, many parents saw the patient clearly for the first time, and some who got glimmerings of their own persistent areas of blindness began to straighten out old difficulties on the spot.

Chapter 9

EVALUATION OF CHANGE IN PATIENTS THROUGH INTERACTION INTERVIEWS

In the effort to develop new and useful techniques for evaluation of the state of illness and changes in the condition of patients among the mentally ill deaf, a series of so-called "interaction" interviews (measurement of timed units of interaction) was undertaken. The experiment was suggested by the work of a number of investigators who had shifted their focus from subjective ratings of the content of interviews to certain more objective characteristics such as form and process. Measures of the duration of subjects' replies, silences, number of interruptions, and the like during a standard interview had been reported by Chapple and others to reflect relatively stable characterologic qualities that seem to change systematically with variations in the condition of patients, medication, and the number of hours of psychotherapy (21, 33, 53, 75, 85). The measurement of the interaction process, as reflected in timed units of patient response or silence, seems especially applicable to the study of deaf mental patients, where subjective evaluation of content of interviews is rendered unusually difficult because of the limitations in communication.

Method

The method used in the project represented a simplification of the standard interviews used by others. Each interview consisted of five initiatives and five responses by the patient. All initiatives were five-second queries by the interviewer, framed as open-ended questions such as a questioning repetition of the patient's last phrase, or an indication of continued interest.

Average length of response, range in duration of response (difference between the longest and shortest response of the interview), latency (time elapsed between the end of an initiative and the beginning of a response), and number of interruptions were recorded for each interview by an assistant who observed the interviews through a one-way mirror and pushed the appropriate buttons on an electrical event-recorder modified for this kind of use. Precautions were taken to standardize the procedures for interview and recording. Interviews were conducted two or three days each week and a weekly summary of data included a clinical evaluation of each patient obtained from the psychiatrist, who included his impression of any change in the patient's condition, experiences on the ward that may have been influential, and changes in medication.

Sample of Patients

Altogether, 11 patients participated in two "runs" or experiments for a total of 330 interviews. The patients chosen constituted an adequate sample of all the patients. They included seven schizophrenic patients, one patient with involutionary psychosis, and three with immature, impulsive character disorders. When the runs were completed, charts were drawn for each patient to show on consecutive days his average length of response, the range in length of response, and the latency or delay in commencement of response, and notes with respect to the psychiatrists' weekly clinical reports.

Results

Representative protocols for each of these steps are available in Appendix C. Figure IV (p. 174) is a typical final chart for one of three schizophrenic patients who were well integrated except in the clearly circumscribed areas of their delusional ideas. While these patients would heatedly answer direct questions about their particular conflicts, they did not usually mention upsetting feelings when they were allowed to guide the interview themselves. This quality of being well-defended, without either undue excitement or psychomotor retardation, is probably reflected in the narrow range of responses and the rather stable average length of response noted in the chart.

For comparison, Figure V (p. 175) summarizes the responses of an extremely unstable, decompensated schizophrenic patient. The different results elicited by altering the schedule of medication are clearly illustrated over the course of interviews. Some pharmaceuticals had no effect, while others (Prolixin plus Cogentin) brought dramatic changes, as the record of wide range of average response and the extreme variability from day to day were replaced by one much like that of the more intact patient.

Conclusions

These charts and more complicated algebraic combinations of the data on variability, latency, silences, and interruptions are under continuing study. While it is unlikely that such measures will ever wholly substitute for clear clinical judgment, they may well have a role in making more objective certain aspects of clinical condition and clinical change. Experience thus far suggests that the measures might be potentially useful as reflections of altered levels of activity which may bear on ease of management. Shifts from hyperactive, excited behavior to quieter levels of better control also parallel clinical improvement in many cases, and the reverse is true as well. Occasionally, however, medication may lead to more tractable behavior without affecting the basic disordered quality of mentation. Whether the method can discriminate this type of change remains to be seen. Nor is it yet clear whether the method will be useful in separating the impulsive behavior of a disordered patient who is not a psychotic from the disorganized, similarly impulsive behavior of certain psychotic patients.

Chapter 10

OCCUPATIONAL THERAPY AND VOCATIONAL ADJUSTMENT

In our society, work satisfies essential needs and each citizen should do some form of work, whatever his limitations. It is to attain this goal for the deaf mental patient that the rehabilitation team strove for the fullest potential permitted within the confines of a patient's illness and abilities. Combining different professional skills and exploring various techniques in each case, the staff was able to develop positive programs for successful rehabilitation. Continued research must be pursued vigorously, however, if a truly comprehensive rehabilitation program for the deaf mental patient is to be successfully extended to the community.

Background

During the initial years of its research (1955-1962), the Mental Health Project for the Deaf confirmed the fact that "some 80% of patients seen in outpatient psychiatric clinics present occupational problems" (11, 41). In a study of the rehabilitation of chronically unemployed psychiatric patients, Stevenson and Fisher pointed out that "continued idleness and unemployment frequently delay final recovery. These circumstances bring an inevitable loss of self-esteem in our society, which values economic independence highly. Such a loss of self-esteem is a vicious circle." (83).

Patients in the project had to overcome both the vocational difficulties that exist for the mentally ill and a number of special problems. A recent report described four of these problems with which the deaf must cope: "1) Emotional instability; 2) social immaturity; 3) educational deficiency; 4) vocational inefficiency. The first three sets of problems have a great impact on the vocational." (90).

Occupational Therapy in the Ward

Every patient on the ward had a special rehabilitation program outlined for him from the time he was admitted until he was discharged. Before beginning to work with a patient, the rehabilitation counselor amassed as much information about him as possible, starting with the careful study of any available past record. At weekly case conferences attended by the patient's psychiatrist and the ancillary staff, the patient's complete diagnostic picture was discussed including data on physical health, level of intelligence and social maturity, and psychiatric classification and prognosis. The charge nurse, who consistently observed the patient, reported on his general behavior, social adjustment, and ability to relate to peers. The rehabilitation counselor scheduled regular conferences with the occupational therapist, who reported findings on the patient's punctuality, neatness, ability to get on with co-workers, dependency needs, work habits, and his reaction to supervision, authority, and stress. With this information, the counselor proceeded with her special duties.

The rehabilitation counselor utilized occupational therapy to motivate a patient to work in the pre-vocational period. Whenever indicated, the therapist tried to develop the patient's span of attention and ability to concentrate. The nature of the workshop on the ward limited the program of occupational therapy to an activity-oriented one, rather than one resembling a true work setting. Patients participated in occupational therapy in a group setting, however, and benefited from the dynamic force which operates when people work together.

Vocational aptitude testing was one tool used to gather extra information. Most of the patients had about a fourth-grade reading ability, so paper and pencil tests were invalid for them. The manipulative tests that measure mechanical aptitude, eye-hand coordination and speed, were more useful.

B. M. Schowe, a labor economics research specialist, translated the use of these tests into the practical setting when he said, "the deaf are most effective on bench work or machines where dexterity is all important." (76). This opinion was upheld by another survey which reported that Lockheed Aircraft Company employed 60 deaf electronic assembly workers. Manual dexterity was mandatory for this work, and Lockheed had discovered that this aptitude was very high among their deaf employees (92).

The vocational rehabilitation counselor learned the stated vocational interests and goals of a patient as she established rapport with him. "Stated" interests were emphasized because it appears that interest inventories used in current test batteries do not discriminate vocational preferences in the deaf (28). When a patient lacked motivation, a primary factor for vocational success, an attempt was made through counseling to arouse more interest. Regular counseling sessions were scheduled for each patient and all aspects of the world of work and what one must do to make that world a reality were discussed at that time. If a patient had a special need at an unscheduled time, he had only to appear at the door of a staff member's office.

Intramural Employment

Female patients whose post-hospital plan was to resume the role of homemaker were placed in the housekeeping unit where cleaning and general housework is done. Those patients whose homemaking skills were limited or needed improvement participated in the hospital's training program in homemaking, conducted by its occupational therapy department, where they received instruction in cooking and general housekeeping. The unskilled patient, for whom no feasible training program was available, presented a different problem. He was placed in hospital industry such as the laundry, kitchen, hospital exchange store, and ground or paint crew.

Appropriate employment was usually found for patients whose special aptitudes were revealed by work history, interview, and the aptitude tests. Female patients skilled as sewing-machine operators were placed in the hospital sewing room on a regular schedule and taught more intricate work on a new machine in the project's occupational therapy department. Male patients who demonstrated manual dexterity were placed in the hospital pre-industrial shop where they were instructed in the use of various machines for woodwork and metal work. A patient experienced in printing was placed in the hospital print shop which is responsible for much of the hospital's published material. Patients with an interest and aptitude for clerical work were assigned to the hospital typing program where a skilled teacher instructed them in regularly scheduled classes. It must be emphasized, however, that none of the in-hospital training programs in typing, woodworking, or homemaking are totally adequate to train a deaf person to qualify for a job in any given field after discharge.

After patients were placed in jobs in the hospital, they were regularly visited by the rehabilitation counselor who observed them in a more practical setting. At the same time the counselor was given a direct patient evaluation from the supervisor. The counselor discussed with the patient anything that arose during the observation period and explored with him any areas of job behavior that needed change. However, to prepare patients in a more realistic way for discharge, there is a great need for more real-life work situations in the hospital setting.

Problems of Outside Employment

When a patient was presented for discharge at the case conference, the post-hospital plan crystallized. If both patient and staff had decided that a training program was indicated to achieve a successful vocational goal, the counselor referred this patient to the State Division of Vocational Rehabilitation (D.V.R.). The requisite medical, psychiatric, and psychological reports accompanied the referral. The ready availability of all necessary background material eliminated the lengthy time lag between discharge and the beginning of a training program. Moreover, the patient received uninterrupted service by continued communication between the project counselor and the D.V.R. counselors who handle deaf clients.

Under present conditions in the community, the most difficult post-hospital plan is for the deaf, ex-mental hospital patient who requires direct job placement. Employer receptivity to ex-mental hospital patients was studied by Olshansky. (61). Of 200 employers interviewed, he found that three-fourths of them expressed a willingness to hire ex-mental hospital patients, but during the three-year period covered by his study, only 27 actually hired any of them. Although no similar study has been undertaken for ex-mental patients who also suffer from deafness, one can reasonably speculate that the employer resistance is even greater.

One source of direct placement available to these ex-mental patients was the New York State Employment Service. In 1965 this agency appointed a special coordinator to work with the deaf who had employment problems, a hopeful development which is too recent for evaluation here because no project patients have yet obtained employment through this source.

Sources of Employment

Every effort was made to secure job placement in the community. Obviously, the success depended upon close cooperation between the vocational counselor, industrial relations people, and other key people in the field. Through such contact three patients from the ward were placed in unskilled jobs.

Case 1: A 21-year-old female who had presented a difficult vocational problem was placed in a housekeeping unit in the girls' dormitory of a local college campus. Because of her youth, it was agreed that some appropriate skill should be developed in a training program as part of her post-hospital plan. Long before discharge her case was discussed with a D.V.R. counselor, who discovered that the patient had already been given three years of service with that agency with no apparent success. It was the feeling of that D.V.R. counselor that unless the patient showed some dramatic change in potential and performance, she would not be eligible for further service now. The only alternative was unskilled work. If the girl could get and hold a job and for an adequate length of time, this might constitute such a "dramatic change" which might make possible a D.V.R. training program.

Fortunately, the minister who instructs the project's personnel in sign language knew that an unskilled job was available on a college campus. The staff counselor accompanied the patient to the interview and found the employers at the college both understanding and sympathetic. They agreed to give a patient a chance, after the counselor assured them that she and the rest of the project staff would always be available should any difficulty arise.

The importance of such continued contact between employer and project counselor was soon confirmed when the patient lost her purse in the subway on her way home from work. Left with no money, and unable to ask even a stranger for help, she could not go to work the next morning. When she failed to report, the employer immediately notified the project counselor, who telegraphed the patient's father. Thus, necessary emergency actions were taken to expedite the patient's return to work. This incident not only verified the need for continuing contact between employer and counselor, but recognized another area of preparation which should be covered with all newly discharged patients—the need to alert and prepare them to handle various emergencies.

This patient remained in that job for nearly a year. She was happy in the work setting, and her employer found her to be efficient, responsible, and thoroughly satisfactory.

Case 2: Because of this success, when a job opened at this same college for a male kitchen helper, the minister again inquired whether a deaf patient was available to fill the vacancy who would live in quarters on the campus. The vocational counselor was then anxiously looking for a job for a 39-year-old male patient who had been hospitalized for many years and had worked long hours in the kitchen. The institutional environment of the college seemed to be ideal for his favorable transition and adjustment. The project counselor accompanied this patient on the interview. After a complete job analysis and a tour of the grounds and living quarters, the patient was accepted for the job. He was eager to begin his new life.

One of the patient's problems had been alcohol, and the project staff recognized that this could be a potential danger as the man acquired money and freedom. Before discharge, he was counseled often and at great length. His after-care sessions were held on a "home call" basis by the project psychiatrist because the college was not within easy reach of the project's clinic, and during these the importance of "no alcohol" was constantly and repeatedly stressed. During the 10 day Christmas holiday when the college was closed, the project staff was admittedly concerned as to what shape the patient would be in when he returned to his job. But the alarm was unfounded. The employer's report continued to be excellent; the patient performed his job well, was conscientious, reliable, and avoided the bottle without apparent sacrifice.

Case 3: The experience of the third patient, a female placed in a job in a laundry, presents a different picture and illustrates still another serious problem in post-hospital planning. This patient had no family at all and no home to which to go. With no other person on the staff to do the job, the rehabilitation counselor assumed the task of finding adequate housing.

After a long and difficult search, a landlady was found who would provide a room with meals and some supervision. The house was two bus rides away from the laundry, and this added immeasurably to the burden of adjustment for a patient who had to re-learn the elementary steps of living in a community after eight years of sheltered, supervised hospital existence. Even such simple acts had to be demonstrated over and over again. The counselor escorted her to and from work until the patient learned the bus routes, she taught her how to deposit and withdraw money from a bank, and she even coached her in the principles of personal hygiene.

After four months of this one-to-one assistance, the whole living situation erupted. While the patient seemed to be "making it," misunderstandings had repeatedly arisen with the landlady. Despite the latter's show of interest, her patience was very limited. Her expressions of sympathetic concern soon gave way to displays of angry personal affront when problems arose. For example, when the patient missed a bath for three days and the landlady abruptly banned her from the living room, "You're too dirty to be with people" was her caustic explanation. The counselor talked with the landlady many times, in person and by phone, but to no avail. The patient herself asked to return to the ward and wait for another home placement.

This unfortunate denouement was primarily due to the community's failure to provide, rather than to the patient's inability to function. As other patients were discharged it became increasingly clear that no matter how much positive movement had been made on the ward, effective rehabilitation depends primarily on how much this movement can be supported and advanced in the community.

Steps Toward Halfway House Program

One positive step of great promise to successful vocational rehabilitation is the development of the halfway house concept. The project embarked on a pilot program with Fountain House, an agency in New York City where ex-mental hospital patients gather and are involved in a unique schedule designed to bridge the chasm back to society. One facet of the program is an apartment arrangement where members live under the agency's supervision. Fountain House had never received deaf patients. As a result of this new program, however, two of the project's patients were scheduled to live in these apartments. It was hoped that this program would provide an answer to some patients who have nowhere to go, or for those who should not return to undesirable environments.

There are many programs and facilities, public as well as private, that still do not serve the deaf. As Williams has pointed out, "there is an under-service of public programs which should serve the deaf. The unique nature of early profound deafness requires special knowledge and skills, which are extremely scarce, in order to extend services to deaf people effectively." (91).

In that same article Williams describes the proposed Vocational Rehabilitation Act Amendments of 1965. All the proposals are excellent and have great significance for the deaf. Amendment No. 2 is especially important for ex-mentally ill deaf people who do not have sufficient potential for competitive employment, because it "gives initial authority for V.R.A. to provide for building, expanding, staffing, and equipping sheltered workshops for the deaf."

Where dependency is a primary aspect of the patient's illness, the sheltered workshop has demonstrated a useful role. Many of the deaf patients in the program had great dependency needs; they were not ready for competitive employment at the time of discharge, and yet they could surely profit from limited work experience. The sheltered workshop program would be a very welcome addition to the post-hospital plan for these patients.

With continuing research, new techniques should be added to those already in use, making possible fuller and more effective implementation of the rehabilitation program for the deaf.

PART III

OTHER MENTAL HEALTH ACTIVITIES AND CLINICAL FUNCTIONS

Chapter 11

OUTPATIENT FACILITIES AND PROCEDURES

The outpatient clinic, which had been set up as part of the original pilot project for the deaf, was reestablished on an expanded basis soon after the onset of the clinical project in 1963. It reopened not only to provide services for outpatients but also to offer aftercare treatment of patients discharged from the hospital.

Number and Age Distribution

During the course of the three-year demonstration program, 119 new patients applied to the clinic, and 96 of them were seen for a total of 1224 therapy or evaluation sessions.* The overall number of new applicants corresponded to that during the latter years of the first project, about 40 new patients per year. Certain other comparisons with the earlier data are of interest. For example, the clinic rolls of the pilot project suggested that persons of middle age and older were under-represented, since they constituted only seven percent of that patient population. This pattern was apparently altered as the community's awareness of the program became more widespread. Table I shows that in the 1963-65 period, 14 percent of clinic patients were in this age range. There was a similar relative increase, from three to seven percent, in the youngest age range (0-12) as the staff of the project moved into closer relationships with schools for the deaf.

* For additional descriptive outpatient data, see Appendix A, Tables VII-X.

TABLE I
Patients of the Deaf Clinic by Age and Sex

Group	Age	Total	Male	Female
Clinic Patients	All Ages	96	57	39
	0 - 12	7	6	1
	13 - 20	41	26	15
	21 - 30	15	10	5
	31 - 40	11	3	8
	41 - 50	7	4	3
	51 or over	13	7	6
	Unknown	2	1	1
Applicants Unable to Attend Clinic	All Ages	23	16	7
Total	**All Ages**	**119**	**73**	**46**

TABLE II
Sources of Referral of Clinic Patients, by Sex

Source	Total	Male	Female
Division of Vocational Rehabilitation	11	7	4
Schools for the Deaf	20	12	8
Organizations for the Deaf	15	6	9
Correction and Welfare Agencies	24	19	5
Hospitals, Clinics, Private Physicians	15	9	6
Family, Friends, Self	32	18	14
Not Indicated	2	2	0
Total	**119**	**73**	**46**

Sources of Referral

Changes from the earlier period in the frequency of referral from various sources are also reflected in Table II. While oganizations for the deaf, the DVR, and hospitals and physicians continued to send patients for evaluation or treatment, the relative number of patients from correctional and welfare agencies that do not have much general contact with deaf clients and have only recently become aware of the clinic increased markedly (from 5% to 20%). Of the total number of applicants, self-referrals and those from friends seemed to become more frequent (from 20% to 28%) as have requests from schools.

While the altered distribution among sources of referrals shifted the emphasis to some extent in the types of patients seen, the composition of the group changed very little with regard to the quality and limitations of communication skills. Table III shows that approximately one-third were considered good communicators, regardless of the mode preferred; more than one-fifth were so deficient in communication of any kind that pantomime, play, and pictures were the sole avenues of contact; and the remaining patients had fair ability in making their thoughts known, although they seldom were able to express freely the nuances of feeling and experience. At the same time, slightly less than half of all the individuals seen used manual language exclusively whatever their level of communication skill, and another quarter supplemented their limited speech with sign language. Speech was the major mode of communication in only 16 percent of cases where information was available, and often this was so inadequate as to be virtually unintelligible.

Reasons for Referral

The most common reasons for referral continued to be acute psychiatric illness, poor work adjustment, social conflicts, and family problems. It is notable that some 76 cases, or 64 percent of the total referred, were sent because of problems of behavior: impulsive, aggressive, unruly, and sometimes bizarre. Of these, 39 had some acutely disabling psychiatric illness, while the other 37 had character problems or transient situational failures in adjustment to particular stresses. On the basis of the quality of behavior alone, the groups were often indistinguishable, and only careful and com-

TABLE III
Communication Skills of Clinic Patients by Sex

Means of Communication	All Grades			Skill in Communication							
				Good		Fair		Poor		Not Indicated	
	Both Sexes	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
Manual Only	55	35	20	10	12	7	2	10	4	8	2
Speech Only (Oral)	15	8	7	2	4	2	2	3	0	1	1
Combination (Manual and Speech)	34	22	12	6	6	3	2	7	3	6	1
Means Not Indicated	15	8	7	0	0	0	0	0	0	8	7
All Means	119	73	46	18	22	12	6	20	7	23	11

petent mental status examination including assessment of historical data, interviews with patient, parents, and other sources, and psychological testing could allow for proper diagnosis. Accurate diagnosis is of course a necessary prerequisite to planning and implementation of any appropriate treatment program.

The tendency of the deaf mental patient to present a clinical picture of disturbed behavior, rather than one of quiet and contained suffering, has been mentioned elsewhere (5, 7, 10). A number of theoretical bases for this tendency exist, taking into account the predilection for expression by action normally epitomized in expressive manual language, and the generally observed limitations in abstract thinking that result in concrete, object-bound behavior. Also synthesized, in another context, have been the psychoanalytic views on the development of internal controls of behavior, the quality of child-parent relationships in normal growth, and what is known of the role of hearing in personality development. This was done in order to formulate an integrated concept of the behavioral and other personality characteristics seen in many deaf persons, and the relative absence of severe psychotic depressive phenomena noted in the first study (6). In these connections it should be noted that of 96 patients seen in the clinic over the course of the present demonstration, there were only three whose distress was of the ego alien, neurotic quality that is internal, painfully constrained yet not acted on, as seen often among hearing persons with neurotic disturbances. Similarly, of five patients with involutional psychotic reactions and three with varying degrees of reactive depressions (those triggered in response to particular events), only one showed the slow, downcast mien, and guilty self-denigrations that typify such disorders in the hearing. The others showed either an anxious or paranoid form of involutional disease, with agitation, somatic concerns, or paranoid delusions as presenting symptoms.

Diagnostic Distribution

The overall population of the clinic reflected every manner of known psychiatric illness, demonstrating that the broad segment of the deaf population that was to be served was in fact reached. The most frequent diagnoses in young adolescents were those of primary behavior disorder and transient situational adjustment reactions, descriptive designations covering a range of disturbances that are of uncertain cause or reactive in nature, but not of a psychotic degree. In adults the most common diagnosis was schizophrenia, with so-called personality-trait disturbances being second in frequency. The latter were usually classified as passive-aggressive personalities or emotionally unstable personalities, in view of the predominance of episodic impulsive outbursts. It was clear, however, that the psychiatric nomenclature as it presently stands does not include the terminology for apt description of the majority of this group of patients.

The standard nosology (22) was developed for disorders observed in the 99.9 percent of the population that is hearing. Therefore, it could hardly take into account aberrant forms of behavior that may develop in the rarer person whose personality must mature in the context of a lifelong absence of audition. Always forced to compensate therefor, and with a variety of additional stresses, the ego functions usually associated with hearing in successive stages of development may very well be stunted, thus predisposing the individual to specific forms of personality disturbance. Many of the patients in the clinic would be best described as impulsive character disorders, if this term is taken to include exaggerated manifestations of the following qualities, to the point of pervasive interference with appropriate social and interpersonal functions: a lack of understanding and regard for the feelings of others (empathy), coupled with limited awareness of the impact of their own behavior on others; an egocentric view of the world and gross coercive demands to have their needs and wishes satisfied; a reaction to frustrations, tension, or anxiety typified by a kind of primitive riddance through action, rather than through internal conflicts with self-imposed controls and constraints.

Clinic Case Load

Of the new patients seen over the three-year course of the project, 30 came for evaluation only, and a number of others received some degree of short-term service, such as determination of vocational goals or counseling and support through acute situational problems. Often some guidance and psychotherapeutic counsel was required in important decisions of marriage and parenthood, especially when the presence of a familial history of deafness or mental illness caused distressing mixtures of inordinate anxiety and genuine concern. The majority of patients, however, qualified for some effort at long-term treatment. Including patients in continued treatment from the initial project, the clinic services logged over 1200 sessions with patients.

The time requirements for such service cannot be calculated by simply multiplying the usual 50-minute session by the total number of visits. Evaluation, testing, and therapy itself demand extraordinary amounts of time with the deaf if rational processes and feeling overtones are to be successfully traced in paths tangled by concrete expression, limited vocabulary, and unusual syntax. It was necessary to vary the length of individual treatment sessions from 15 or 20 minutes up to two and even three hours according to the individual need. While routine follow-up for stability on long-term medication may at times be quickly handled, amelioration of acute exacerbations in difficult family situations is often enormously complex. In such cases the sterility of the therapeutic field cannot be maintained by exclusion of relatives and other interested parties as is usually the case with hearing patients. The deaf patient's silence, besides isolating him from meaningful self-expression, may also serve as a screen for family members to play out their own complicated neurotic difficulties. In many cases it was necessary to make personal contact with employers and to provide family counseling. The latter procedure often presented the question: How far could the therapy of other family members be carried without diverting the clinic's resources from its primary task of providing psychiatric services for the deaf? As a matter of practical necessity, such interventions were limited to guidance directed towards deepening the understanding of difficulties encountered by the deaf family member and towards highlighting those individual and family attitudes that made successful resolution more difficult. If further work was necessary or unyielding personal problems were uncovered in the family member, referrals were made to community mental health centers or other facilities.

From the foregoing it can be seen that a great variety of services were required. It is also evident that statistical assessment of treatment results must remain a virtual impossibility. Establishment of matched controls—a most uncertain procedure with this complex and puzzling group—would mean refusing services to a number of needy persons who might potentially benefit. Uncertainties regarding nomenclature and the atypical syndromes often seen would only heighten the difficulties of comparison. The small sample size in each category of illness would limit the statistical significance of all but the most dramatic differences between treated and untreated groups.

An effort was made to obtain follow-up information on those patients from other states who traveled to the unit for evaluation, but whose place of residence made continued treatment impossible. Most of those patients were unable to realize fully the recommendations made because their communities had limited facilities for the deaf. The general failure of this group to improve might be ascribed in large part to this absence of continued and integrated treatment. However, distance generally precluded controlled follow-up by means of a thorough reexamination by the project's staff.

Patients treated in the clinic often presented problems which, if not met, would be expected on clinical grounds to grind slowly downhill and interfere ever more pervasively with adaptation. This fact made it possible to evaluate certain cases by having each patient serve as his own control. As described in Chapter 4, the course anticipated on initial evaluation, in an untreated state, could be compared with the actual outcome observed under conditions of treatment. More severe limitations had to be prescribed for prediction in outpatients than for inpatients, for the histories of illness were often more brief and less illuminating for prognostic purposes, and the course of neurotic and situational disturbances is in general less certain than for psychotic disorders of long standing. At any rate, evaluation by these means suggested that about *one-fourth to one-third of the clinic patients would be judged improved despite a clearly poor prognosis.*

It may be of equal value and more illustrative use to abstract briefly a few cases that demonstrate some of the problems encountered and the techniques found helpful in meeting them.

School and Family Problems

Case 1: D. L. was an 18-year-old congenitally deaf boy referred to the clinic by the D.V.R. as a maladjusted youth, irritable and uncertain, who had expressed vague ideas of killing himself. These symptoms had become apparent over the last two years and seemed to have increased in intensity as the time for graduation from high school approached.

His middle class, intellectually aspiring family had a background negative for deafness or mental illness. The boy was an only child, and had been the center of family interest, a focus heightened by the additional concerns of his grandparents who lived in the same home. While seeming to accept his deafness, and doting on him as if he were helpless in many ways, the family continued to expect from him a level of scholastic and cultural achievement commensurate with their own social status. The father particularly had nurtured high hopes of college-level performance from the boy and often expressed his impatience and frustration at the son's lukewarm scholastic interest.

Psychological and psychiatric examination revealed a boy of somewhat better than average intelligence, acutely aware of a responsibility he felt to be excessive. He was grappling helplessly with feelings of inadequacy, fears of being on his own away from home, and anticipatory shame at the possibility of failure to pass the impending college entrance examinations. While he preferred above all a job that would make him self-supporting, he also yearned to fulfill his parents' hopes and remain the deserving apple of their eye. He was fully aware of the advantages to be gained through further education, and he intended to take the examination. In the face of this conflict he had become increasingly tense and morose, and was unable to sleep.

The immediate therapeutic problem was to relieve the patient's symptoms and help him through the tests, a month away, without precipitating a further breakdown. His progress in preparing for them was discussed at weekly sessions, and his major concerns were explored. Through these discussions his range of acceptable alternatives was broadened and he was made to see that everything did not hinge on whether he passed or failed. His mother frequently was a participant in the sessions, and when the effects of the family's pressures became clear to her, she effectively shifted ground and helped her husband to alter his attitude as well.

Relieved of excessive expectations, the boy studied well and seemed to blossom visibly into more direct and independent activity. While waiting for the test results, he sought out and looked into a number of job situations to see if they might be suitable for him. Almost symbolic of his greater freedom of expression was the fact that he had his first sexual contact with a girl at this time; he told his parents of it, as well as his therapist, with a certain pride. When he was later informed that he had failed to qualify for college, he was only moderately disturbed and even recognized a faint sense of relief.

As he continued to inquire into work possibilities, the therapy explored other sources of the tension that remained. He was often upset and had a certain guilty sense of failure that seemed related to the bickering between his parents.

Not understanding the content of their arguments, he felt himself to be the unhappy source and cause of their anger and discontent. When this was discussed with the patient and his mother, she made it quite clear that the marriage was a stable one and that there were seldom arguments related to the boy. She quickly recognized how, having been the focus of so much concern, he could make himself the center of any unhappiness that might arise. The frank discussion that ensued from this clarification also marked a changing recognition of the patient as an individual by his parents and himself. Through subsequent referrals from the clinic, he found a job in a factory. It required some skill and paid reasonably well; the boy was conscientious in his work and pleased with himself.

Impulsivity and Inadequacy

Case 2: A. M., a 21-year-old deaf man, was referred to the clinic for having severely beaten his infant son. As a result of the beating, the child had been hospitalized with multiple fractures, internal injuries, and spasticity of the legs which made it uncertain that he would ever walk.

The youngest of five, the patient had a passive father and a mother who made all financial and child-rearing decisions, supported the family, and later even aided the patient and his wife financially. As the baby of the family, he was indulged by his mother from the beginning, the more so after meningitis at age three left him totally deaf.

At school, he was considered a behavior problem and was expelled a number of times for getting into fights and occasionally stealing. He was active sexually as an adolescent, proud of the prowess he attributed to his "tough guy act". At 19 he met an attractive but helpless, dependent, and immature girl, who was congenitally deaf. When she became pregnant, they got married. During the wedding party, he had several fist fights.

Another pregnancy shortly followed the first, and the patient began to feel the turn of the screw. He was temporarily unemployed and his inept wife relegated the major share of the baby care and housekeeping to him. He would strike her in frustration, and run from the house, afraid he would really injure her. Once she refused intercourse and he exposed himself to a woman nearby for symbolic reassurance and retaliation.

The second child was a son. In elation, the patient named the child for himself and spent all of his savings buying gifts. Then he lost his job again and became increasingly concerned about his financial position. One night during an argument he struck his wife and she became hysterical. He had been feeding the baby, and threw the bottle at her. When the baby cried and vomited, he beat the child and ran away. When the hospital physicians later advised him of the damage he had done and suggested psychiatric treatment for himself, he immediately acquiesced and was admitted briefly to the hospital.

The hospital authorities called upon the outpatient clinic for the deaf and simultaneously referred the case to the district attorney's office. Psychiatric and psychological examinations revealed an impulse-ridden personality, in a man of average intelligence. He was dependent and demanding, with mild depressive trends and anxiety, but clearly not psychotic. When his wife refused to testify against him, the threat of an indictment for assault vanished. With it went most of his impetus for treatment. He felt somewhat calmer on medication and tended to deny the possibility that he would become excited again.

Against the advice of the project's psychiatric staff, he eagerly insisted on the return of his child. The hospital delayed as long as possible but finally had to capitulate. By this time his wife was pregnant again, and both refused to consider seriously the possibility, urged by the clinic, of interrupting the pregnancy. The patient attended the clinic irregularly, and then not at all.

The referral source was notified of his failure to cooperate. Within a short time, it was learned that his son was hospitalized for injuries once more. This time the possibility of court action was always kept in the forefront. That leverage moved the patient into more active cooperation. In addition it served to keep the real consequences of his behavior in sight, and prevented him from denying all problems by returning home with the illusion of a normal and happy family. The child was separated from him and retained in the hospital. Through a series of interagency conferences, financial aid was arranged and a part-time homemaker was provided to assist and instruct his wife in the essentials of running a household. With ultimate success depending to a considerable extent on her growth, regular counseling sessions were instituted for her with a warm and insightful social worker at another agency, with whom she had already established a comfortable relationship.

The patient himself was seen for treatment on a once-a-week basis. The goals throughout were to break through his denial and to shift his source of self-esteem from the conception of himself as an attractive "tough guy" to the more realistically enriching bases of success as a father, husband, and provider. It was also hoped through these efforts to afford some pride in establishing a measure of self-control and diminish his neurotic involvement with his son as a frustrating, helpless, and inadequate extension of himself.

The first area approached in treatment was the less threatening, more neutral ground of his vocational performance. He had always worked irregularly and relied on his mother to bail him out financially. The incongruity between this childlike dependency and his wish to see himself as a strong and manly figure was emphasized, and he began to try for a more responsible approach to work. The therapist had to make several direct interventions with employers when misunderstandings arose and there were some anxious periods of unemployment. Over a year, however, the patient changed jobs frequently, and a general improvement of both performance and financial position resulted. As he derived some pleasure from these changes, the feelings of helplessness that were implicit in his outbursts at home began to be explored. His wife's concomitant improvement provided a valuable assist. With the reduction of pressure, his own irritability and childlike demands were highlighted, and he began to see that he could feel more strength in providing aid than in helplessly giving way to a tantrum.

After two years of treatment, the family was reconstituted (now with three children). The patient worked regularly and well in a well-paying job for six months, and with the exception of occasional minor arguments a level of stability was achieved. He visited the clinic every two or three weeks and treatment was scheduled to discontinue shortly.

Paranoid Symptoms

Case 3: L. K., a tall and attractive congenitally deaf woman, was 41 years old when she was transferred to the service for the deaf early in 1963. During the preceding 12 years she had been hospitalized five times, each admission lasting longer than the one before. The psychological examination and psychiatric interview confirmed her earlier diagnosis of paranoid schizophrenia, and she was delusional and hallucinating after more than a year of treatment at the transferring hospital. She remained in the special unit for ten months more, was followed as an outpatient for close to two years, and was then discharged with the proviso that she could return for visits whenever she felt the need.

She was the youngest child of a middle-class Italian couple, with no family history of either deafness or mental illness. Her four siblings were hearing and it was the family theory that her deafness resulted from her mother's attempts to terminate the pregnancy by taking a variety of pills. Guilty parental arguments attended the patient's development, and, coupled with the sense of her own difference, may have increased her growing conviction that she was stupid, despicable, and a freak. Throughout her childhood she was suspicious and irritable and had frequent temper tantrums.

Leaving school for the deaf at age 17 with the equivalent of an eighth-grade education, she spent a few years in a trade school and then worked briefly as a sewing machine operator. She left this job because of an intolerable sense that her coworkers were talking and laughing about her. At the age of 26 she married a deaf man who proved to be steady and a good provider, and two years later she gave birth to a normally hearing girl. Six months afterward she became impatient with having to care for the baby, developed ideas of reference and persecution once more, and was hospitalized for the first time. Over the succeeding years she was treated with several courses of electroshock and various medications. Each time she was placed on convalescent care she refused to come for clinic visits, discontinued her medication, and within a short time developed a new recrudescence of symptoms.

Admitted to the special ward for the deaf she alternated between passive cooperation and periods of extreme disturbance, hallucinating, screaming, and cursing God, spitting at the television set, and throwing ashtrays and other objects about the room. She had no insight and felt that all of her hospitalizations had been unwarranted.

With individual psychotherapy three times a week and psychotropic medication, her condition gradually improved. She attended the group sessions and began to relate, at least superficially, to some of the other patients. Her therapist saw her immediately whenever there was an acute flare-up, and she seemed to welcome this relationship, perhaps the first enduringly positive one in her life. She was often delighted and amazed that he could anticipate and understand her feelings. She soon accepted the fact that he respected her delusional beliefs of being Jesus and persecuted by God, but would not deceive her by agreeing with her about them. Instead of attempting a fruitless direct attack on this system, the therapist concentrated on uncovering the historical bases for the angry feelings of worthlessness which underlay the grandiose and persecutory ideas. At the same time he attempted to build up her self-esteem by a more realistic and positive view of herself.

The patient gradually spoke less of her delusions and more of her lifelong sense of being an outsider in the family, and her feelings of how her parents—neither trusting nor believing her—seemed always to prefer her sister. She recounted her childhood recollections of lying alone in bed, apprehensively asking herself, "what's wrong with me! what's wrong with me!"

The therapist also worked closely with the patient's family from the beginning, in an effort to prepare them for her ultimate discharge. He obtained reports of her behavior on the home visits initiated toward the end of her hospital stay, he made direct suggestions with regard to problems that came up during them, and used family reports in the therapy sessions with her.

When the patient was placed on convalescent status at her parents' home, the unit's social worker undertook a series of regular visits. In a sense, these extended therapy to the family, for they became group counseling sessions usually directed at the mother's critical and ill-timed prescriptions as to the time and method of doing household chores. When a part-time job was found, the patient accepted it eagerly despite her poor work history and considerable apprehension about being able to work with strangers. She showed no recurrence of symptoms and held the job for over a year. However, its promise as a stepping stone to full-time employment failed when the increasing incapacity of her aging parents made it necessary for her to take over the management of the home. During the course of her convalescent treatment she also made peace with the idea of maintenance medication for an indefinite length of time. She was seen weekly for a year, bi-weekly thereafter, and discharged symptom free.

Discussion of Illustrative Cases

The three cases illustrate classes of illness that posed particular problems of varying difficulty when it came to prediction. The first case is representative of situational disturbances, family problems, or acute adjustment reactions of different phases of life. The second is of the impulsive character type discussed earlier in this section. The third illustrates a well-established schizophrenic reaction, characterized by relapses and varying levels of remission. A common sense judgement would suggest that all three would have done poorly without some psychotherapeutic intercession, but this is not enough for predictive certainty. The family in the first case, being interested, could conceivably have become aware of the problem; or the boy—after failing—might have reestablished his equanimity alone. The second case would probably have resulted in divorce, but it is possible that each partner would have managed to keep well. Only the third case could be considered one where the clinical course and the history of illness would have made spontaneous recovery a virtual impossibility. Yet in evaluating the services provided in all three cases and the results, it would be hard to deny the fact that benefits accrued to each individual.

The three cases have other implications as well. For a successful resolution, the first type requires a certain minimum of basic strength or resiliency of the individual. Equally important is a family structure where interest in the child is not heavily counterbalanced by neurotic investment in him, or by fixed character problems in the parents that lead to anxiety or angry flight from the clinic when interpretations confront them with their own distorted feelings. As mentioned elsewhere, there are certain clues which can alert the professional observer to the fact that a family problem may underlie the patients' symptomatology (5). Among these clues are dissatisfaction at several schools for the deaf, reports that a number of agencies have been uncooperative, and allegations of intelligence and language skills far better than are actually possessed by the patient. The presence of family conflict about deafness may also be reflected by the history of refusal by the patient to wear a hearing aid, unrealistic pressures toward achievement, or irrational and extreme feelings about the inadequacy of manual language. These findings, if extensive, augur poorly for outcome. In the first case presented, the family was basically healthy, and their interest in the boy was for the most part conflict-free. (It should be emphasized, however, that the staff has seen no hearing family that does not evidence ambivalent feelings toward their deaf child, accentuated by actual frustration, and guilt and shame over a dimly sensed "failure" in reproduction.) Their genuine interest and willingness to face quickly certain discomforting recognitions about themselves were invaluable in securing a resolution of the problem.

The second case, representing character disturbances or neurotic traits, graphically illustrates the variety of therapeutic techniques that had to be applied to assist deaf persons with such problems to achieve and maintain stability of function. Close work with other agencies had to be continued in conjunction with a balanced program of psychotherapy that emphasized, on various occasions, support, direct guidance, and the development of insight. The course of work might be fraught with intransigence on the part of patients, in this case their closing the door to meaningful discussions regarding the advisability of having more children, and the initial lack of motivation or awareness on the part of both husband and wife. Work and home eruptions often required direct action, by the therapist or social worker, of a kind and degree that may be uncomfortable for professionals grown accustomed to the insulated one-to-one relationship of general psychotherapy. Bursts of erratic behavior frequently threatened whatever progress had been made, so that the outcome was always uncertain, and the sensation remained of sitting on a powder keg with sparks flying nearby. Yet with sufficient attention, including home visits, maintenance of an alliance with employers, and cooperative endeavor with others concerned, the way could often be smoothed and stability of home and patient maintained.

The third patient, a chronically relapsing psychotic, offered little difficulty in prognosis; without treatment, the outlook was decidedly bad. Once remission was achieved through intensive inpatient work, the task was to help arrange her life circumstances and continue to assist her through therapy, so that relapse was not inevitable. The techniques just discussed are almost always necessary in this type of case as well. It may be noted that in previous remissions the patient had stopped attending aftercare clinic after a few visits and all touch with her had been lost shortly after her release from the hospital. The continuity of treatment guaranteed by the nature of the project's organization effectively prevented this lapse of interest on the part of the patient. As an outpatient, she reported to the same doctor who had treated her in the hospital, and the sense of helpful alliance established during the hospital course was further expanded as she made progress outside. The staff was available through a number of ups and downs, offering assistance geared to whatever needs were most immediate.

Value of Aftercare Program

By keeping in touch with patients and their problems and by providing flexible and appropriate help when needed, the staff enabled patients to remain functioning in the community. Only in this way could problems be nipped in the bud and insurmountable complications avoided. Since many of these patients were chronic, it seemed likely that their attendance at the clinic would extend over several years, with visits perhaps diminishing in frequency rather than being limited to the one-year follow-up currently maintained throughout the state.

There was no doubt that this total approach to aftercare was responsible for the fact that only one of the 22 patients leaving the ward required readmission because of illness, a record unmatched by any other facility for hearing or deaf. It is of course too early to tell whether these results will hold, for a number of patients have been out of the hospital only a short time. Several years of further work are necessary to provide a large enough sample for comparative evaluation of five-year remission rates, but an auspicious beginning has been made.

Through similar individual attention and close working relationships the clinic also has been able to avoid hospitalization in a number of chronically ill persons who joined its rolls as outpatients. A weakness here is the total absence of day care or halfway house facilities equipped to deal with the deaf. Were this deficiency remedied, the preventive aspect of the project's work would be enhanced considerably and the needs for hospitalization further reduced.

Group Therapy in Clinic

One interesting development was the spontaneous tendency of patients to use the clinic as a place of social contact as well as therapeutic support. Apparently less sensitive to the social stigma of mental illness than the hearing, the deaf patients appeared pleased to meet old acquaintances while waiting for their own appointments. After inquiring about the progress of friends made in the hospital, many requested that their next appointment coincide with another's so that they might exchange notes more personally. Taking advantage of this type of interest, the staff often arranged for such meetings of the patients in small groups. The groups were managed in much the same way as group therapy in the hospital. Here, however, the intensive interchanges and curiosity to know about each other's struggles in the hearing world were exploited in order to widen interests, to maintain the helpful tie with the clinic, and to provide sympathetic support and a socially mediated control in the individual's own efforts to settle into normal life.

For some of the clinic patients, prompt hospitalization and intensive treatment, necessitated by acute illness or exacerbation, kept to a minimum the time that patients were sequestered from the community.

Genetic Counseling

An important aspect of the clinic work was the expansion of genetic counseling services, relating to the vital decisions of marriage and parenthood. The virtual absence of genetic knowledge in the deaf community had been highlighted in the previous pilot study (4). The vast majority of congenitally deaf adults preferred a deaf mate while expressing a desire for hearing children. Yet they were totally unconcerned about whether the mate's deafness was congenital or acquired. Even those few individuals who expressed a preference for having deaf children gave no indication that the genetic aspect of their mate's deafness was an imperative factor for consideration. Historically, this unfortunate lack of all but the most rudimentary or superstitious sense of genetic factors that bear on the potential for psychotic forms of mental disorder has not been limited to the deaf community. In recent years, however, the impact of careful documented genetic studies has gained headway among professionals in psychiatry and the social services. Kallmann's thorough surveys in this country, and those of Slater, Essen-Möller, and others throughout the world demonstrated the large and graded increase in schizophrenic risk, for example, as shared genetic factors were increased with close relationship to an identified index case (25, 40, 77, 79, 84). Investigation in the deaf population of New York indicated that deafness contributed little to the likelihood of developing a schizophrenic process, compared to the importance of such shared genetic background (12).

An increased curiosity and interest in these important areas was engendered by the work of the mental health project from the beginning. Early resistance to the project's efforts, born of the misconception that the deaf were being singled out as "sick," was replaced by enthusiastic support as the realization took hold that equal and effective services were the goal. A volunteer association for mental health among the deaf in the community was the spontaneous issue of this new understanding, and it provided a forum for further educational discussions whereby knowledge of traits with familial distribution could be disseminated. As a result, increasing numbers of better informed deaf individuals and hearing members of deaf families, sought counsel with regard to marriage and parenthood. While it is unlikely that deafness or mental illness will disappear through such eugenic measures, the relief of anxiety or avoidance of certain tragedy for even a single person cannot be overvalued.

Chapter 12

PSYCHOLOGICAL SERVICES AND TESTS

The psychologist in the program for the deaf was charged primarily with the responsibility for diagnostic psychological testing. He also shared with the psychiatrists the case load for individual psychotherapy both for inpatients and clinic patients. In addition, he fulfilled a number of ancillary functions, including supervising the school program for hospital patients, working with the rehabilitation counselor in social and vocational placement, and helping to evaluate deaf patients in other hospitals throughout the state system.

Teaching Program

With respect to the teaching program, the psychologist met regularly with the part-time school teacher to assist him in planning curricula and devising teaching procedures and techniques. Patients attending the school varied widely in age, scholastic background, and degree of psychopathology, so the teaching goals, materials, and techniques had to be modified considerably from patient to patient. In addition to supervising the teacher in these matters, the psychologist acted as liaison between the teacher and other members of the staff.

Psychological Testing

As with hearing patients, the main purpose of giving psychological tests to the deaf was to obtain as much information as possible to help in evaluation of the patient. Information was sought to determine the current level and patterns of intellectual function, intellectual potential, personality traits, and emotional disturbances and their prognosis. The findings were useful in making a differential diagnosis, in educational and vocational planning, in estimating prognosis, and in providing guidelines for those areas to be dealt with in treatment.

The psychologist relied heavily on the recommendations of Levine (50) in selecting tests for appraising deaf psychiatric patients. To evaluate mental functioning, and for certain diagnostic clues, the Wechsler-Bellevue Intelligence Scale, Form 1, the Wechsler Adult Intelligence Scale (WAIS) or the Wechsler Intelligence Scale for Children (WISC) was used (87, 88, 89). The Rorschach, Thematic Apperception Test (TAT), Figure Drawings, and House-Tree-Person Test (HTP) comprised the personality tests (20, 52, 57, 74). The Bender Visual Motor Gestalt Test (17) was also included in the battery, principally as an aid in the detection of brain damage.

An effort was made to administer the battery to the vast majority of patients, hospitalized and outpatient, where questions of diagnosis suggested their potential usefulness. Occasionally a clinic patient discontinued visits before testing was complete, or a patient might have been missed because of case-load pressure. A few patients were so disturbed, disorganized, or unable to communicate that any kind of testing was impossible. Thus, the full battery or as much of it as was deemed appropriate or possible in a given case was given to some 39 percent of the 169 in- and outpatients of the present project (1963-1965). This includes 70 percent of inpatients, and 26 percent of outpatients.

Table I summarizes the tests used with this group, and shows that 73 percent of these patients received at least a Wechsler performance scale and either the Rorschach, the TAT, or both. The tests most frequently dropped from the battery were the Wechsler verbal scales. This decision was made when limitations in verbal ability or scholastic or experiential background indicated conclusively that verbal scales would contribute little or nothing to the evaluation. A few patients refused to cooperate when it came to taking emotionally loaded tests like the TAT and Rorschach. Generally speaking, the deaf are as cooperative as hearing patients, if not more so, and such refusals were rare.

TABLE I
Frequency with Which Various Tests Were Employed in the Psychological Evaluation of 66 Clinic and Hospital Patients

Tests Employed								Number of Subjects	Percent of Subjects
Wechsler Verbal	Wechsler Performance	Rorschach	TAT	Bender-Gestalt	Bender-Gestalt Recall	House-Tree-Person	Figure Drawings		
X	X	X	X	X	X	X	X	13	19.7
X	X	X	–	X	X	X	X	5	7.6
X	X	–	X	X	X	X	X	2	3.0
–	X	X	X	X	X	X	X	12	18.2
–	X	X	–	X	X	X	X	14	21.2
–	X	–	X	X	X	X	X	2	3.0
–	X	–	–	X	X	X	X	11	16.7
–	–	X	X	X	X	X	X	1	1.5
–	–	X	–	X	X	X	X	2	3.0
–	–	–	X	X	X	X	X	1	1.5
–	–	–	–	X	X	X	X	1	1.5
–	X	–	–	–	–	–	–	1	1.5
–	–	–	–	X	–	–	–	1	1.5

Administration of Tests

The psychologist used various modes of communication including speech, writing, manual language, and gross pantomime when administering the tests. Regardless of which method was appropriate for the patient's level of skill in communication, great care was necessary to insure a clear understanding of what was expected. Unless instructions are fully appreciated, results will be irregular and an accurate interpretation of the tests impossible. For this reason, much more time was devoted, for example, to preliminary demonstration of the performance subtests of the Wechsler tests. Instructions for some of the subtests had also to be simplified.

The Levine adaptation of the Wechsler-Bellevue Form 1 (50) was used with patients who demonstrated sufficient verbal facility to make testing with verbal scales meaningful. Eliminating as much as possible those features of the original scale which made it unsuitable for use with the deaf, Levine tried to simplify the language and concepts used in the instructions and test items while keeping the level of difficulty unaltered. This adaptation of the scale proved most useful in a number of cases, but it was essential nonetheless that the psychologist be continuously alert for the patient's misinterpretation or inability to comprehend test items. Whenever a response suggested a failure in understanding, the test item was reviewed again.

In general, there was little difficulty in conveying to deaf patients what was expected on the graphic tests (Bender Gestalt, HTP, and figure drawings). It was also usually possible to administer the TAT in the conventional manner, the only alteration being simplification of instructions.

Use of the Rorschach test required greater modification of instruction and procedure for inquiry. The deaf patients seemed unusually ill at ease when faced with the amorphous unstructured quality of the blots, more so than hearing patients with comparable illnesses. To minimize their anxiety and elicit the maximum cooperation, the psychologist presented the test as a matter of imagination, stressing that there were no right or wrong responses. After spontaneous reactions to the first two cards were recorded, more than the usual amount of encouragement was given in an attempt to draw out additional responses. Frequent reassurance about the adequacy of a patient's productions was also necessary throughout the test. Great and careful effort had to be expended to clarify determinants of response. Many patients, especially those with the most limited skills in communication, gave markedly unelaborated or vaguely specified responses, such as "animal". When other attempts at clarification failed, the patient might be asked to draw the specific animal that he had in mind. This technique was also used when patients were unable or unwilling to indicate the area of the blot involved in their responses.

With the exception of these variations from standard technique, the testing procedures of Klopfer, Ainsworth, Klopfer, and Holt were followed rigorously (45). Evaluation of Rorschach protocols was also based on the interpretative hypotheses utilized by these authors with respect to the various scoring categories and their interrelationships.

Evaluation of the Battery of Tests

The battery of tests that was employed had both merits and limitations. Some of the limitations are inadequacies inherent in the tests themselves; others come from the characteristics of deaf patients that complicate the administration of the tests and assessments of their results. In the category last mentioned fall those shortcomings already implied, most notably that some of the most rewarding tests (especially the Wechsler verbal scales and the Rorschach and TAT) could not be used with a clear sense of accuracy for a number of patients with significantly limited verbal and other communicative skills. The potential usefulness of expanding the battery of tests to include the Szondi (23) and other tests not yet used with the deaf remained under continuing study.

A major limitation of the battery as a whole was that most of the tests were developed and standardized for use with hearing subjects. Despite the urgent need, few if any comparable tests have been designed exclusively for the deaf (50). Moreover, most studies of the performance of deaf subjects on the Wechsler-Bellevue Form 1 and the WISC suffer from limitations in scope and inadequacies in design which make the validity of reported findings questionable at best.* According to the literature, not a single effort has been made to standardize the WAIS with the deaf, although this test has been in use since the early 1950's. The criticisms leveled at the Wechsler studies are for the most part equally applicable to those few investigations of how the deaf meet such tests as the Rorschach and TAT.

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* Some of the most frequent and glaring limitations of these studies include the use of small or highly selected samples of subjects, failure to apply adequate controls, and use of non-comparable control groups. For a thorough critique of psychological studies of the deaf, the reader is referred to the excellent reviews of Barker and Wright (14) or Levine (51).

In consequence, there is a virtual absence of reliable normative data for comparative use in evaluating the test results of deaf patients with mental illness. Blind use of hearing norms would be foolhardy and extreme caution was necessary in deciding to what extent deviations in performance represented pathology, or were the natural consequences of deafness in the specific context of an individual patient's language facility, scholastic and experiential background, and the like.

For example, a tangential or irrelevant response to a test item on the Information, Comprehension, or Similarities parts of the WISC or WAIS generally could not be taken as an indicator of disturbed thinking, as it might be with the hearing. Such responses among the deaf were most commonly based on faulty comprehension or flagging interest. Similarly, oddly stated answers, poor syntax, and confusing verbalization are the rule among deaf patients and cannot always be taken as guideposts for the extent of pathology.

The limitations of even the performance subtests of the Wechsler for interpretations with the deaf have recently been emphasized. The assumption has been that since instructions can be conveyed through pantomime, and responses do not require verbal facility, the various subtests may be considered as equally non-verbal in nature. Myklebust (58) stressed the mounting evidence that all of the tests are not equally non-verbal, and also made the point that while deaf and hearing subjects might achieve identical scores on test items, they may be making use of different psychological processes in doing so. In other words, the problem-solving task which is measured can be quite different for the two groups if they are not drawing on the same abilities. These facts are bound to influence the patterning of subtest performance, and have immediate relevance to clinical practice for the psychologist trained to attribute diagnostic and clinical significance to the patterning of Wechsler subtest scores.

Most of the above also holds for the use of the Rorschach and TAT tests with deaf patients, where there are additional difficulties as well. The most common problem in these projective tests was the paucity of responses usually evoked. The majority of the deaf patients tested produced Rorschach and TAT protocols that were limited both qualitatively and quantitatively, consisting of but few responses with a minimum of elaboration or qualification. TAT stories were usually no more than two or three sentences in length, and more descriptive than discursive. The general dearth of Rorschach responses precluded the use of sequence analysis in almost all cases, a procedure which is often productive and revealing. In a number of cases it was virtually impossible to score the Rorschach protocols formally, for the patient would not—and frequently did not seem to be able to—delineate his responses. Even the use of the graphic technique described earlier sometimes failed to clarify matters.

Unscorable Rorschachs were also obtained from certain patients who were totally lacking in any conventional means of communication. In these instances the psychologist was forced to get assistance from relatives who had generally developed a private system of communication with the patient. Such reliance is a risky procedure in giving any test, although gross misrepresentations of the patient's response could usually be detected by the psychologist. When the choice was between following this procedure or administering no tests at all, it was felt to be justified.

Indeed, even fragmented and imperfect protocols were often able to provide diagnostic clues. In spite of the many shortcomings of the test battery, it must be stressed that the tests were useful in many important respects. Augmented by close and careful observation of the patient as he approached his tasks, the administration and readministration of the battery generally gave a reasonably valid assessment of level of intellectual functioning and capacity, major personality traits, adequacy of controls, diagnosis, and prognosis. Support for the validity of test-based inferences came from their high concordance with independent opinions of the psychiatric staff.

Psychological Test Results

This section will report on the results of intelligence testing and on the Rorschach material of a series of deaf patients examined by the psychologist over a period of close to three years. The series includes all patients given psychometric tests and 22 schizophrenics; the latter represent all schizophrenics fully tested except those cases requiring interpretative help from relatives and those who produced unscorable protocols. Thus the schizophrenic sample is selected, as well as heterogeneous, and generalizations drawn from the data must be limited. While the data cannot be taken as normative in the strictest sense, they should provide at least a descriptive portrait of the kinds of patients tested over the course of the project. Further accumulation and expansion of such data should lead to the development of norms. This goal could be accelerated considerably if a central agency for the collection of data were available after other special units are established in other states.

Wechsler Intelligence Test Results: Table II tabulates 60 patients according to age and performance IQ. The patients included 35 hospitalized cases and 25 clinic patients. It can be seen that the clinic patients as a group were somewhat younger than the hospital patients, the mean age of the former being 26.3 while that of the latter is 30.0. Seventy-two percent of the clinic patients were under 30, while 63 percent of the hospital patients were in the 20-39 year range.

The table also shows that the mean Performance IQ of the hospital group was considerably lower than that of the clinic group (88.5 as opposed to 99.3). While this could signify that outpatients were a brighter group, a more likely explanation is that the difference in mean IQ's reflects the greater severity of disturbance in hospitalized patients. The IQ distributions of both groups are skewed to the right, with a disproportionately large number of subjects below the average range of 90-110. Rather than signifying the true proportion of subjects with sub-normal potential, it is probable that these distributions also reflect the impact of emotional disturbance on intellectual functioning. Not only were all of these patients disturbed to some degree, but the majority had socially, scholastically, or culturally deficient backgrounds as well. All of these factors would act to lower achievement on the Wechsler performance tests.

Rorschach Test Results: Few Rorschach studies of the deaf have been published, and only one deals with deaf schizophrenics. The findings of Levine's well-designed investigations of the Rorschach performance of normal deaf adolescents (49) were used to provide a rough comparison with 22 schizophrenics tested over the course of this project. Since the two groups

TABLE II

Age and Wechsler Performance IQ Distribution of 35 Hospital and 25 Clinic Patients

	Clinic Patients		Hospital Patients				Clinic Patients		Hospital Patients		
Age Range	Number of Patients	Percent	Number of Patients	Percent	Both Groups	IQ Range	Number of Patients	Percent	Number of Patients	Percent	Both Groups
10-19	13	72	7		20	69 or below	0	40	2	45.7	2
20-29	5		13	62.9	18	70-79	3		10		13
30-39	3		9		12	80-89	7		4		11
40-49	0		2		2	90-99	1	36	10	40.0	11
50-59	4		1		5	100-109	8		4		12
60-69	0		2		2	110-119	3	24	3	14.3	6
70-79	0		1		1	120-129	2		1		3
80-89	0		0		0	130-139	1		1		2
Total Patients	25		35		60	Total Patients	25	8	35		60

differ in several ways, the present schizophrenic sample was also compared with the criteria for normal hearing persons. Baroff's (15) discursive report on 10 schizophrenics represented selected patients from New York State's pilot project (1955-62). Since he made no mention of the age, schooling, or verbal facility of the patients and presented no quantitative data, the results could not be compared systematically with the present survey.

Levine's experimental group comprised 31 females between the ages of 15 and 18. All subjects had been rated as normal adolescents by competent judges, and they were matched for age and sex, and in terms of scholastic background, age of onset and degree of hearing impairment, and the hearing status of their parents. The subjects could be considered representative of a considerable proportion of the total deaf population 15 to 18 years old.

The schizophrenic deaf patients of the present report comprise 22 in- and outpatients. The Rorschach test was employed profitably with several additional schizophrenic patients whose protocols had to be excluded from systematic analysis. In some of these cases responses were so poorly delineated with regard to location, determinants, or even content that their records were largely unscorable. Unavoidable exclusion of some of these most disturbed protocols of course may bias the data to some extent. Other Rorschach data were excluded where testing was not complete. This could occur as a consequence of time limitations, or if only selected blots were administered to confirm an abundance of other diagnostic clues. Finally, Rorschach protocols which were not included because of their dubious reliability were obtained from patients whose language was so personal that the family had to interpret it.

Table III classifies the 22 patients in terms of age, sex, IQ's, schooling, and socio-cultural background. It can be seen that the age span of the subjects was quite broad, ranging from 16 to 41. The variability in age is not a major weakness of this sample, however, since 20 of the patients (91%) were between the ages of 20 and 39 and only one patient slightly exceeded this range (age 41). Basic personality structure is well established by age 20 and probably does not generally change very much from age 20 to 41. Another factor in terms of which group members are reasonably homogeneous is chronicity of illness. In 18 of the 22 patients, historical data and staff opinion indicated that the schizophrenic process was of long duration.

TABLE III

Classification of 22 Deaf Schizophrenic Subjects by Age, Intelligence, Education and Socio-cultural Background

		Wechsler Intelligence Quotients			Socio-cultural Background		
Sex	Age	Verbal	Performance	Education	Inferior	Average	Superior
F	36	–	74	Some High School	X		
M	23	–	102	Some High School		X	
F	24	–	94	Some High School	X		
F	37	89	112	High School Graduate		X	
F	30	73	102	High School Graduate		X	
M	30	103	91	High School Graduate		X	
M*	24	–	–	Some High School		X	
F	41	95	107	High School Graduate	X		
F	36	–	72	Some High School	X		
F	24	93	81	Some High School			X
F	28	101	111	Some High School		X	
M	24	76	73	Some High School	X		
M	28	127	139	College Graduate			X
F	34	–	88	Grade School Graduate	X		
F	35	82	90	Some High School		X	
F	23	–	122	Grade School Graduate		X	
M	26	104	111	Some College		X	
M	27	78	95	Some High School		X	
F	38	–	78	Some High School		X	
F	16	–	79	Grade School Graduate	X		
M	35	105	128	Some College		X	
F	29	–	81	Some High School	X		
				Sum =	8	12	2

*Not given intelligence test

Examination of the IQ distributions reveals several kinds of variability. Nine patients received no Wechsler verbal test because of extreme deficiencies in verbal skills. Considerable variability in level of intellectual functioning is evident in the distribution of verbal and performance IQ's. The verbal IQ's range from 73 to 127, a difference of 54 IQ points; six fell within normal limits, one was above average, and the remaining five patients tested below average.

Performance IQ's of the group were even more variable, ranging from 70 to 139 for a difference of 69 IQ points. Of the 21 subjects, seven achieved IQ's in the average range, six were above average, while eight fell below normal limits. Of the latter, only three were in the dull-normal range (80-90), while five were in the borderline range (70-79). Both the verbal and performance IQ distributions were skewed to the right, indicating a disproportionate number of subjects with below-average functional intelligence.

Another factor in which the group varied significantly is amount of education. At one extreme were three patients who had attended Gallaudet College for varying periods of time. At the other extreme were six patients who only attended grade school, again for varying periods of time. The middle group of 15 patients completed from one to four years of high school.

In the last three columns of Table III, the patients are classified in terms of socio-cultural background. This is an admittedly crude classification, the psychologist relying on evaluation of case history material and impressions gained from interviews with patients' relatives. It can be seen that according to this classification, eight patients were considered to have inferior socio-cultural backgrounds, 12 were average in this respect, and two superior.

In summary, the group was relatively homogeneous with regard to severe hearing impairment, either congenital or acquired at an early, pre-speech age. The vast majority were also chronically ill. On the other hand, they varied with respect to amount of schooling, verbal skills, level of intellectual functioning, and socio-cultural backgrounds. They also differed in the types of school attended and the hearing status of their parents. All of these factors can have a significant bearing on Rorschach performance.

Levine's group obviously differs from the present one in a number of ways and cannot be used for a controlled comparison. Hers are the best normative data to be found, however, and the contrast with the patients studied here is of interest if differences are interpreted cautiously. Other differences between the two studies are that Levine conducted her inquiry after each card, and used the interpretive hypotheses of Beck (16) and Piotrowski (62); with the deaf schizophrenic patients, the inquiry was conducted in the standard fashion, after responses for all 10 cards, and interpretations were made according to the hypotheses of Klopfer, Ainsworth, Klopfer, and Holt (45).

Results and Interpretations: The data of the present study will be compared with those of Levine and with the key criteria originally established by Rorschach (74) and supplemented by Klopfer and Kelly (46). The key criteria represent the hypothetical, optimal, normal Rorschach performance of hearing people. The three groups of data are summarized in Table IV.*

Inter-group comparison of the data reveals some rather striking differences. These differences will be discussed in the order in which the factors (Rorschach scoring symbols) are listed in the left-hand column of the table.

R (total number of responses). While the mean R of the normals, 25.7, fell within Key Criteria limits, that of the schizophrenics, 18.3, fell below these limits. This is also apparent from examination of the last three paired columns which gives the percentages of records in the two groups which are within, above, or below the Key Criteria limits. Only 20 percent of the normals fell below the Key Range of R as compared with 68 percent of the schizophrenics. Since R is a measure of productivity, the data suggest that deaf schizophrenics tend to be considerably less productive than are their normal counterparts or normal hearing persons.

One might expect that the very real perceptual and conceptual limitations of the deaf would diminish R markedly, regardless of whether they are normal or schizophrenic. This did not prove to be the case with Levine's subjects, however. The diminished R of the schizophrenic could reflect not only underproductivity but also such things as associational impoverishment, limitations in adaptability to new situations, or impairment of capacities for differentiated perception and abstraction.

Another factor to be considered is anxiety aroused by the lack of structure in the blots. About half of the 22 patients were so threatened by the

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* The format of this table is adapted from that of Levine (49).

TABLE IV

A Comparison of the Rorschach Performance of Deaf Schizophrenics with That of Normal Deaf Subjects[1] in Terms of Rorschach Key Criteria[2] of Optimal Normal Performance for Hearing Subjects

Factor	Key Criteria (in % or Frequency as Noted)	Normal Deaf Frequency Range	Schiz. Deaf Frequency Range	Mean Frequency		Mean Frequency %		Records within Key Range (%)		Records above Key Range (%)		Records below Key Range (%)	
				Normal Deaf	Schiz. Deaf	Normal Deaf	Schiz. Deaf	Normal Deaf	Schiz. Deaf	Normal Deaf	Schiz. Deaf	Normal Deaf	Schiz. Deaf
R	20-40	11-42	5-44	25.7	18.3	–	–	74	27	6	5	20	68
W	20-30%	0-9	0-16	3.1	5.2	12.0	28.0	13	18	10	50	77	32
D	45-55%	7-33	0-26	18.5	8.7	72.0	47.5	3	14	97	32	0	54
d	5-15%	0-12	0-7	2.8	1.2	11.0	6.6	29	27	26	14	45	59
Dd & S	< 10%	0-8	0-10	1.3	3.0	5.0	16.3	90	50	10	50	0	0
M	2-4	0-6	0-4	1.5	0.7	6.0	0.4	29	18	6	0	65	82
F	50%	9-38	3-37	19.8	14.0	77.0	76.5	0	0	97	91	3	9
F+	70-80%	5-26	2-32	13.8	9.3	78.0	50.8	48	14	36	41	16	45
FC	1-3	0-2	0-2	0.2	0.3	0.9	1.6	13	27	0	0	87	73
CF	0-1	0-4	0-6	1.7	0.8	7.0	4.4	39	14	61	18	0	68
C	0	0-2	0-12	0.1	0.5	0.4	2.7	94	95	6	5	0	0
A	30-55%	2-27	0-24	15.4	8.0	60.0	43.7	29	41	58	41	13	18
P	> 5%	1-9	0-7	5.0	2.4	19.0	13.1	0	0	61	14	39	86

[1] Figures for normal deaf from Levine (49)

[2] Figures for normal hearing (Key Criteria) established by Rorschach and supplemented by Klopfer and Kelly (46)

test blots that they seemed at a loss about what to do with them. Five other patients were somewhat uncomfortable, but no more so than many hearing subjects. The remaining six patients seemed relaxed while taking the test.

W (responses involving all or most of the blot areas). Table IV shows that while the normal deaf had a pronounced tendency to underproduction of W, perhaps the opposite was true of the schizophrenics. Fifty percent of the latter group exceeded the Key Criteria in W production; 68 percent fell within or exceeded criteria limits in this respect.

W responses can vary considerably in quality, and interpretations vary accordingly. At one extreme are W's based on analysis and integration of blots in a realistic and creative manner. At the other extreme are "cheap" W's which are no more difficult to produce than responses involving only parts of the blots. Such W's are seen in a global, undifferentiated manner and may also involve poor match between concept and blot. W's of the first type were rarely produced by the patients. Instead such responses usually had the global, undifferentiated quality indicating limited integrative or planning effort or capacity.

Much the same can be said about the majority of responses produced by the patients, regardless of whether they were W, D, d, or Dd responses (cf infra). The quality of responses gave the impression that most of the patients had regressed from, or more likely had never reached, an adequate level of personality organization and differentiation.

Six patients attempted to produce integrated whole responses but few were successful. In some of these cases the motivation to produce W seemed to be an over-extension of capacities, reflecting a failure to recognize personal limitations. With the others, differentiated W responses reflected a fear of leaving anything to chance, with the patients driven to account for all areas of the blot. Both kinds of patients would often defy the reality of the blot form, showing little awareness of the incongruity of blot area with the concept advanced. The content of these integrative efforts seemed to deal more frequently with internal body organs than is the case with hearing schizophrenics. Determination of which blot subdivision would be labeled a particular organ was dictated primarily by the relative position in the blot rather than its shape; i.e., these were classical Positional Responses reflecting a pathological reasoning process.

DW. These responses, indicative of pathological part-to-whole reasoning, were given very rarely. Only two of the patients produced them; each gave only one such response.

D (large, clearly demarcated blot sub-divisions). Both the normals and schizophrenics deviated from the Key Criteria to a large degree in production of D responses, but in opposite directions. The vast majority of normals (97%) overproduced D's, while more than 50 percent of the schizophrenics underproduced D's.

Traditionally, D responses have been considered indices of interest in and responsiveness to the commonplace and obvious, a reflection of a concrete, practical-minded set. However, as with all Rorschach interpretations, interpretive hypotheses attached to D vary in a given patient with their relationship to all of the other Rorschach factors.

The excessively high production of the normal deaf may reflect limited integrative drive or a need to cling to the familiar and obvious to maintain feelings of security. Underproduction of D, common to over half of the schizophrenic subjects, is probably based on the fact that their disturbance impairs the capacity to appreciate obvious aspects of situations. The relatively low number of P (popular) responses given by the patients adds support to this hypothesis.

d (small but clearly demarcated blot sub-divisions). The largest deviation from expectancy with respect to this factor is underproduction by the schizophrenics. This too suggests a less-than-average awareness of and responsiveness to obvious details.

Dd & S (rare location areas). The most striking deviation here is the overproduction of Dd by half of the schizophrenic group. Levine reported that the bulk of such responses in her group were S responses, and she interpreted this as indicative of oppositional tendencies. The Dd:S relationship was the opposite for the schizophrenic group, suggesting that these people guard against uncertainty by restricting their attention and involvement to minute and inconsequential aspects of the environment.

W%—D%—d%—Dd & S% (manner of approach). Table V presents the experience balances (ratios of W:D:d:Dd+S) for hearing normals, deaf adolescents and deaf schizophrenics. The schizophrenics appear notably different from both other groups, producing a considerably greater number of W responses, markedly fewer D responses, somewhat fewer d responses, and considerably more Dd and S responses. It can be observed that with the exception of the Dd and S%, the manner of approach of the schizophrenics is more similar to that of the hypothetical optimum for hearing subjects than is that of the normal deaf group. All of these, however, are location responses. It should be borne in mind that deaf schizophrenics may produce a series of responses scored (for location) as similar to those of a hearing and normal person but arrived at by means of psychological processes that are quite different. As noted earlier, qualitative aspects must also be taken into account in any effort to interpret the meaning of a patient's percepts.

The core meaning of the manner of approach is that it reflects the balance or lack of balance of an individual's intellectual approach to his experiences. Table V indicates that in the normal deaf group there was an under-emphasis on an abstract, integrative approach (W%). The schizophrenics on the other hand produced an average number of W's within the Criteria Range but many of these were more like D responses in the sense that they reflected very limited integrative effort. Also apparent in Table V is a stronger-than-normal tendency for involvement with the insignificant, minute, and irrelevant.

F% (% of exclusively form-determined responses). Returning to Table IV, it can be seen that both the normal deaf and deaf patients produced an abnormally high number of pure F responses. Nine of the 22 patients, almost half, had F% in excess of 80. So high a proportion of F responses is considered pathological, implying such limited intellectual and personality

TABLE V

Experience Balance for Hearing, Deaf, and Deaf Schizophrenic Subjects

Group	Mean W%	Mean D%	Mean d%	Mean Dd & S%
Hearing Normals	20-30	45-55	5-15	0-10
Normal Deaf Adolescents (Levine)	12	72	11	5
Deaf Schizophrenics	28	47.5	6.6	16.3

differentiation that response is limited to the bare outlines of reality. There is little awareness of one's own needs or of the nuances of emotional surroundings. Ten of the 22 patients had F%'s between 50 and 80. These patients also suffered from considerable personality constriction, but to a lesser extent than the nine patients just described.

F+% (the ratio of all good pure form responses to total pure form responses). Data in Table IV indicate that great differences occurred between the normal deaf and schizophrenic groups with respect to F+%. Far fewer schizophrenics than normal deaf showed normal F+%'s; far more fell below the criterion range in this factor. This is in line with the expected results, as F+% is a measure of objectivity and reality testing capacity.

M (human movement responses). It can be seen that production of M responses by both deaf groups falls far short of normal limits. M production in general requires a fairly high level of ego functioning. Its presence in adequate numbers within the context of good level of reality testing suggests relatively free access to phantasy activities, tolerance of archaic impulses whose energies can interfere with creative activity, good empathic capacity, and internalization of controls. M therefore not only is a reflection of a well-integrated personality, but also links inner resources with such outward-directed functions as reality testing and object relations. Meager production of M by both deaf groups suggests important deficiencies in personality structure. More specifically the finding suggests that basic capacity for reality testing, control, and object relations are limited in many deaf people, regardless whether they are normal or schizophrenic.

FC, CF, & C (Color responses with varying degrees of form). Production of color responses fell below normal expectancy in both normal deaf and schizophrenic subjects, except for a normal production of CF responses in the deaf adolescents. Color responses in general are considered to represent both the degree to which a person is overtly emotionally responsive to his environment (especially other people) and the quality and amount of control which characterizes responsiveness: FC responses represent controlled, adaptive, and mature responsiveness, while CF's reflect a more spontaneous quality. Both FC's and CF's should ideally be present, with the former predominating. Predominance of CF over FC suggests responsiveness of an immature, impulsive, self-centered, and uncontrolled quality. Color responses that are completely without form are extremely rare and indicative of pathology. Only one of the 22 patients produced pure C responses.

Table IV shows that both normal deaf and schizophrenic subjects produced very few FC responses. All of the normal deaf, but only one-third of the schizophrenic deaf, produced an average or greater-than-average number of CF responses; the other two-thirds of the schizophrenic subjects produced no CF's. These data suggest that the responsiveness of the deaf normal group tends to be impulsive, immature and non-adaptive. The fact that over two-thirds of the patients produced neither FC nor CF responses implies that the schizophrenics as a group were relatively unresponsive to environmental impact.

A (animal responses). It can be seen that substantial proportions of both the normal and schizophrenic groups (58 and 41%, respectively) gave more than the optimal percent of animal responses. High A% is felt to reflect a sterotyped view of the world, i.e., a narrow range of interests.

P (popular, frequently given responses). Both the normals and schizophrenics deviated from the optimal criteria range but in different directions. The normals showed a tendency to overproduce P's while the schizophrenics underproduced them.

P% is a measure of the extent to which a person's thinking conforms to that of others. Relatively high production of P's in the normals suggests overconformity in thinking at the expense of originality or a reflection of the tendency, already mentioned in connection with this group's high D production, to be primarily responsive to the most obvious aspects of their experiences.

The tendency of the schizophrenic group to underproduce P is not surprising. It shows what one would predict, namely, that they are deficient in capacity to think along the same lines as others do.

Summary of Intergroup Comparisons and Conclusions

R—While 80 percent of the normals were within key criteria limits, the R's of 68 percent of the schizophrenics fell below the limits.

W%—In the normal group the W% of 77 percent of the subjects fell below the key range. Most of the schizophrenics, 68 percent, had a W% which was either within or above the key range.

D%—Both groups deviated from the D% key range but in opposite directions. Ninety-seven percent of the normals had D%'s above the range while 54 percent of the schizophrenics fell below this range.

d%—Substantial proportions of both the normal and schizophrenic groups (45 and 59%, respectively) underproduced d's.

Dd & S%—Only 10 percent of the normals produced disproportionately large numbers of rare details and space responses as contrasted with 50 percent of the schizophrenics.

M—Both groups showed a marked tendency to give few M's.

F%—A very high proportion of both groups had F%'s exceeding the key criteria range.

F+%—Eighty-four percent of the normals had F+%'s within or above the key criteria range. About half (45%) of the schizophrenics had F+%'s below the criteria range.

FC—Production of FC responses was very limited in both groups.

CF—Over half (61%) of the normals gave more than one CF response while 68 percent of the schizophrenics gave no CF response.

C—Pure C responses were exceedingly rare in both groups.

A%—Large proportions of both groups, 58 percent of the normals and 41 percent of the patients, exceeded the key criteria range for A%.

P—Among the normal subjects 61 percent produced more than five P responses while 86 percent of the schizophrenics gave less than five P's.

Discussion of Findings

Levine's study showed that the Rorschachs of 31 deaf normal subjects deviated significantly in a number of ways from hearing normals. The most obvious implication of this finding is that use of Rorschach normative data of hearing subjects is inappropriate in evaluating protocols of the deaf.

In the present report the Rorschachs of 22 deaf schizophrenics were compared with those of Levine's 31 normal deaf subjects. It was observed that the two groups differed, often markedly, in a number of Rorschach scoring factors (particularly R, W%, D%, Dd and S%, F+%, and P%). What is more, both qualitative and quantitative differences in these factors were generally in the directions one would anticipate.

The value of the findings in the current study is diminished by the fact that the two groups are not comparable with respect to a number of significant variables such as age, schooling, and sociocultural background. It is possible that when sufficient Rorschach records of deaf schizophrenics have been accumulated to allow for adequate matching of schizophrenic and normal deaf groups, some of the differences reported in this chapter will not be found.

Despite this inadequacy, study of the Rorschachs of deaf schizophrenics has proved of value. On the one hand, it has served to provide hypotheses which can be tested as further data accumulate. More immediate in its bearing is the demonstration that experienced use of the Rorschach with deaf schizophrenics can provide accurate interpretable information for evaluation in this clinical group.

Chapter 13

PROFESSIONAL TRAINING AND COMMUNITY EDUCATION

Since the entire mental health program depended on finding qualified professional personnel and obtaining community support, training and education were essential portions of the project. Training programs for the patients have already been described. The training program for new staff members was supplemented by education of the deaf community to recognize the problems of mental illness, and promulgation of interest in the deaf and better knowledge of their problems among professional groups in the mental health field.

Training in Communication

Ever since the original pilot program began in 1955, it was the conviction of the workers on the project that if psychiatric and psychological interviews with the deaf were to be fully effective, they could not be carried on by means of a third party interpreter.

All of the patients were in the adolescent and adult years; most of them communicated exclusively by manual forms of language, others combined these with some speech, some were primarily oral, and a few unfortunate patients developed no method of communication at all save for simple gestures. Thus, the most important denominator in staff training was providing experience in sign language and finger spelling so that patients and personnel could communicate freely. Weekly lessons in manual communication by qualified instructors were given the entire professional staff. Many of those so trained continue to staff the present program; some have left to pursue research and clinical activity in other settings. During the early years of the first project, communication instruction was also given to a number of nurses and attendants at nearby hospitals who had contact with individual deaf patients.

With the establishment of the clinical demonstration project, the number of persons to be trained in sign language increased greatly. Even before the opening of the ward, the classes were moved from the Psychiatric Institute to Rockland State Hospital. Within three months all new staff members including the psychiatrist, psychologist, nurse, 10 ward attendants, occupational therapist, and vocational counselor were able to converse manually and were prepared to greet the first patients when the ward opened officially. With expert instruction, it was possible to provide the rudiments of "basic sign language" in so short a time.

Many benefits accrued to both patients and staff. The most important was that group therapy became a dynamic therapeutic tool as 10 to 15 patients and one or two staff members communicated manually and interacted freely. Moreover, the ward attendants were assigned a more important role in the patient care than is usually given that category of employee. Because their communication skill was sharpened by continuous classes and daily conversation with patients, attendants were assigned to work directly with patients in the occupational therapy shop, the game room, at meals, and in athletic and recreational activities.

Training in Problems of the Deaf

However, education in sign language was not itself sufficient to equip the staff for work with the deaf. The principal aim of the training program was to create a highly specialized cadre of mental health workers equipped to admit, treat, care for, and rehabilitate into the community deaf patients with a wide range of psychiatric difficulties. Depending upon his professional training, each staff member received instruction in various aspects of those areas concerned with deafness and the deaf. This included the educational, psychological, and vocational implications of deafness; the problems of early detection, assessment, and differential diagnosis of deafness; and the dynamics of patient-staff relationship and ward management problems. Moreover, to prepare these specialists for working with agencies and relatives concerned with the patients in the clinic and on the ward, it was essential that they acquire firsthand knowledge of community organizations of and for the deaf and knowledge of the intrafamily problems in homes of the deaf.

Training of Workers for Other Regions

An incidental advantage of this program was that it stimulated an interest in the field of deafness among many specialists not permanently attached to the unit, thereby equipping them to staff outgrowths of the program as similar mental health facilities expand into other parts of the country and indeed around the world. To this end, psychiatrists in residency training at the New York State Psychiatric Institute were rotated through the unit at two-month intervals. This provided six young men each year with an intensive introduction to this special area of deafness and the deaf. Should even one or two of them be motivated in the future to devote time to psychiatry for the deaf, an important goal will have been achieved.

In addition, the presence of the unit for the deaf at the state hospital indoctrinated many of the general staff of the hospital, from psychiatrists to supervising nurses, attendants, and occupational instructors, in problems encountered with deaf patients. The permanent establishment of a statewide program for the deaf will certainly perpetuate the process of establishing this important special area of mental health endeavor.

Training of Deaf Laymen

Another major educational goal was accomplished as the comprehensive mental health services aroused the interest of an active group of deaf laymen. As they increased their knowledge about matters of mental hygiene, many served prominent roles as volunteers in the program. A mental health association of the deaf was formed and its meetings were addressed by professional members of the project's staff and by deaf members of the mental health committee of the Empire State Association of the Deaf. As a result of this greater interest and activity among laymen, misunderstandings regarding the stigma of mental illness were reduced and proper procedures of clinic referral, hospitalization, and convalescence were clarified. Reports were made to such groups as the National Association of the Deaf, the National Convention of the Jewish Deaf, the Empire State Association of the Deaf and the Union League for the Deaf, the Conference of Leaders of New York State Organizations for the Deaf, and the Gallaudet College Alumni Association.

Community education was increased by the lectures on mental health given by the project's staff members to parents' associations of local schools for the deaf and to teachers and houseparents. It was planned to expand this area of preventive psychiatry in the next phase of the work.

Contact with Professional Community

Still another important educational endeavor was the dissemination of the results of psychiatric experience to professional groups in the mental health community including psychiatrists, psychologists, social workers, rehabilitation workers, audiologists, otolaryngologists, religious counselors, and other groups working with the deaf (See Appendix E). In addition, the publications of the project's staff members received wide distribution.

A special program held at Rockland State Hospital soon after the clinical program was in operation provided a practical demonstration for over 100 guests, including directors of other state hospitals, representatives of the U.S. Vocational Rehabilitation Administration, the New York, Massachusetts and Pennsylvania Divisions of Vocational Rehabilitation, Gallaudet College and schools for the deaf. The program was addressed by the Commissioner of Mental Hygiene, the Director of the Hospital, and the Director and staff members of the Project. Patients were interviewed to illustrate early, middle, and improved stages of treatment. All special rehabilitation, group and occupational therapy, and educational programs were demonstrated.

Throughout its course, the project provided blueprints for initiating similar programs to mental health groups in other states and groups from many foreign countries who made special visits to the unit.

PART FOUR

PRELIMINARY EXPLORATION OF NEW APPROACHES

Chapter 14

PREVENTIVE PSYCHIATRY IN SCHOOLS FOR THE DEAF

It is widely accepted that neurotic disturbances of character and adjustment have their roots in early experience. Constitutional factors, elements of stimulation, internal hormonal effects and the like all contribute toward normal and aberrant development, and a number of sophisticated investigations have focused recently on teasing apart their individual effects (24, 31, 32, 36, 48). By the time a person reaches the school years, these elements are inseparably entangled, acting upon each other to perpetuate earlier developments toward health or illness, and so as to take in fragments of current experience according to an already established set. Usually it is entrance to school that provides most children the first opportunity for contact with persons outside the family who might observe, influence, and attempt to ameliorate the manifestations of incipient disorder.

That deaf children require the maximum use of this opportunity should be self-evident. Their early isolation, the confusion and distress of parents, and the need to mature in the face of the severe handicap of absent audition, have been highlighted in a number of reports (2, 26, 42, 49, 60, 93). A previous study demonstrated that deaf criminals and offenders consistently showed a history of behavior difficulties while in school (66). Their files indicated a number of points at which therapeutic intervention might have interrupted the vicious cycle of provocative behavior stemming from a variety of dynamic roots, and they clearly show the increasing frustrations of surrounding adults, who ultimately threw up their hands in helplessness regardless of their initial tolerance. Moreover, since the psychiatric work with the deaf began, many clinic referrals were from schools, for sexual problems, stealing, and other symptoms of disturbed personality.

Pilot Consultation Program in School for the Deaf

In an attempt to determine the extent of the need for psychiatric attention, while providing whatever services were possible, the psychiatric staff undertook a series of weekly consultations at one school for the deaf* during the school sessions from September 1963 through December 1965. The school enrolls 277 students from ages three and one-half to 19. There are 190 boys and 87 girls, and most are residential pupils, going home only for weekends.

Altogether on these visits 37 students were seen for individual evaluation, almost all returning one or more times as necessary for reevaluation and revision of the treatment program outlined. Working jointly with the project staff members, the school's psychologist and social worker made up a mental health team that translated the psychiatrist's recommendations into action, counseling with the students and interpreting and consulting as necessary with teachers, cottage parents, and the administration. The diagnostic range included 16 behavior disorders of childhood, 14 incipient character problems, three children with mental deficiency, and four with childhood schizophrenia, with an age range of four and one-half to 18. Two of the schizophrenic pupils and six other students were seen for weekly psychotherapy by the psychiatrist. These eight pupils at the least were clearly enabled to remain in school and made acceptable progress through these efforts.

Problems aired were those to be expected in any school-age group: poor academic performance, intransigence and disciplinary problems, temper tantrums, hyperactivity, stealing, and sexual misbehavior. More striking was a curious widespread lack of group cohesiveness even among adolescents, the absence of that sense of cameraderie epitomized in the common youthful gang. Despite considerable interest and a great deal of active experimentation there was also an abysmal lack of any codified, accurate knowledge of sexual and reproductive function.

* The New York School for the Deaf, White Plains, New York

The precise bases for the latter findings are uncertain, but probably have their roots in the combined effects of experiences to which the deaf youngster is exposed and those from which his perceptual deficiency excludes him. For example, to bridge the isolating barrier of deafness a great deal of individual instruction is required, and even in the later years of school the major teaching effort is necessarily to get information to the deaf student. It would appear that because of the enormous work involved in providing the elements of an education to students of limited vocabulary and skill in communication, the development of creative endeavor and independent thinking may be relatively neglected. Indeed, it has been noted that many students used to being spoon-fed may resist encouragement to more active, free-wheeling participation (94). Long years of sequestered living in residential schools may also tend to foster a dependence, leading to self-concern and apathy towards the needs of others. Similarly, with limited levels of communication, social taboos are perceived, but reasons for their existence remain poorly apprehended. The complicated nuances of social and sexual mores, rules and roles in dating behavior, mutual responsibilities, and even a clear understanding of reproductive function also tend to be misconstrued and vaguely defined.

Experiments in Group Interaction

During the second year of work at the school an innovation was attempted in which several students were seen at once in small groups. The purposes were to explore the potential for interaction between students, to study and encourage them in developing group feelings and responsibilities, to define and help with common preoccupations or concerns, and to look for possible age- or sex-specific differences in patterns of thinking. In this experience, the findings described above were clearly discernible. One group of boys between 10 and 12 years of age, for example, seemed virtually unable to establish a group relationship. For several sessions they remained six individuals, uninterested in and uncommunicative with each other, each clamoring for the doctor's atention. Because of time limitations, the potential for change in this group was left unexplored, and further efforts were limited to two groups of older students: boys 13 to 16 years of age, and girls 13 to 15. The boys' group was further selected so as to comprise children in whose families paternal guidance and support had been particularly limited.

These boys gradually developed some sense of group identity and mutual awareness. This change appeared to be a response to the doctor's management of the group since such developments would probably not have taken place spontaneously. For example, the boys at first behaved very much as had their younger counterparts, each directing his comments only to the doctor. When a question raised by one of the members was referred for answer or opinion to another of the group, the initial response was generally a blank stare and shoulder-shrugging lack of interest, even when comprehension of the point at issue was ensured by several repetitions, simply rephrased. Slowly this almost total indifference yielded as the doctor pointed out areas of shared opinion or common concern.

The group and individual preoccupation with violence and retaliation was a notable example of this growing awareness. The boys read little, had verbal language of poor intelligibility, and in the early meetings seldom reported spontaneously on events of the weekends at home. Yet, when a local Sunday paper showed a picture of a seven-year-old boy accidentally shot by his brother, each student mentioned the story independently, and all had taken the pains to apprise themselves of every surrounding detail. When each boy recognized that the others were equally interested and upset, a turning point was reached in the emergence of group feeling.

A similar point was noted somewhat later, when one little fellow—a recent transfer—complained of being in trouble with the bigger and older boys. A stocky member of the group said that he had had that problem too, but that he was now bigger and life was easier. The psychiatrist asked the huskier boy to advise the smaller one how best to manage, and finally suggested that perhaps he could take the newcomer in charge and lend some direct, and even protective, help. Both reacted to the suggestion with surprise and yet with evident pleasure. From this beginning a fast friendship formed that would otherwise not have been established; needless to say, the well-defended little fellow, helped over the rough spots, made a more comfortable adjustment.

The group's preoccupation with violence might have had its roots in the adolescent immaturity of the members, in dormitory living with its inevitable peck-order, and in the tendency of the primitive talion law to dominate when social and conceptual experience are limited. The behavior, interest, and adaptability of cottage parents plays a potentially important role in perpetuating or modifying these concepts. It is to be hoped that expansion of the project's work will lead to a closer working relationship with the cottage parents whose responsibility for virtually all of the students' out-of-class time has traditionally outpaced the qualifications demanded in hiring, and the status accorded the job.

The girls' group was more communicative from the outset. Each seemed more aware of others, and somewhat more capable in certain areas of abstract thinking. For example, the boundaries between borrowing, giving, and stealing were less blurred among girls than boys, and though both groups were concerned with sexual exploration and its consequences, the girls seemed to evince a more farsighted interest in defining the future roles of wife and mother.

Conclusions drawn from these trial experiences necessarily had to be tentative. One cautious impression was that group meetings of students under professional direction would be an important adjunct in a preventive mental health program at a school for the deaf. Such meetings might be the best forum for encouraging independent discussions, the growth of awareness of the feelings of others, and for promoting that sense of mutual concern which is the foundation of community responsibility. They might also be the most natural setting for providing students with a basic understanding of the facts of sexual function and with psychological guidance in the rules, roles, and stumbling blocks in the developing of mature relationships. For best effect, the meetings could be extended to include groups for parents of the students, for they too were often found to be in need of understanding such basic facts of life.

Chapter 15

HALFWAY HOUSE AND DAY CARE SERVICES

While the treatment programs in the clinic and hospital provided the impetus for psychiatric improvement, the need for extensive supervision of patients' activities during convalescent periods became more and more evident. The use of the clinic in this role has been alluded to earlier, but the clinic itself could only provide a small opportunity for increased social contact and support. Still prominent were the bottlenecks that blocked free access to the community for deaf patients ready for discharge. Delays were frequently occasioned while staff workers vainly sought for homes that could provide adequate supervision for the patient making his first steps in adjustment outside the structured life of the hospital. Placements which seemed opportune could shortly prove inadequate, and patients carefully prepared for community living might be returned to the hospital. Such disappointments and disruptions could precipitate exacerbations of illness and undo months of careful work. Similar situations obtained in regard to job placement and coordinated entrance into retraining programs, both for in- and outpatients.

To meet these issues, the project staff explored a number of possibilities. Regular location of foster homes willing to accept deaf mental patients proved impossible, and placement in the usual rehabilitation programs unequipped to deal with their special needs was difficult and usually fruitless. During the latter part of the project, tentative arrangements were concluded with Fountain House, a well-established halfway house in New York City, whereby suitable deaf patients would visit the facility before discharge and be prepared to take part in the program afterward. The Fountain House program places discharged patients in apartments and arranges supervised work ranging from office and thrift shop duties to automobile care and industrial activities. Through a series of mutual training conferences, the staffs of the unit for the deaf and Fountain House coordinated the beginnings of what could be a major advance in the aftercare of deaf patients.

When the project ended in December 1965, four female patients were participating in this plan under the integrated supervision of both facilities. Patients obviously benefited from having continuous supervision by alert professionals with open lines of communication. For example, a 23-year-old girl with paranoid schizophrenia and a history of three decompensations and seven years of hospitalization, was placed with a hearing roommate. A letter noting the death of a pet she had been fond of caused her to feel depersonalized and to develop ideas of being stared at, written about, and the like. Her roommate and the halfway house staff noted the change the next day. The clinic was notified immediately and a two-hour emergency visit was scheduled. The patients medication was increased and her feelings explored, and for several days thereafter the project's social worker visited her at her new home and at her place of training. With this help the crisis abated, the patient remained functioning, and the need for another hospitalization—a virtual certainty without such prompt action—was averted.

The full potential of cooperative rehabilitation programs such as that with Fountain House will be explored in a new demonstration program begun at the conclusion of this present project (cf Chapter 17).

PART FIVE

CONCLUSIONS AND RECOMMENDATIONS

Chapter 16

SUMMARY OF MAIN FINDINGS AND THEIR IMPLICATIONS

When the psychiatrists and other mental health workers attached to the Department of Medical Genetics of the New York State Psychiatric Institute began their investigation of the psychiatric needs of the deaf in 1955, they could only dimly foresee the nature of the comprehensive clinical services that would be required. It was first necessary to learn about the deaf community, a hitherto neglected area. What were its number and distribution, its genetic and fertility characteristics, and its vocational, sexual, and social problems? The answers to these and other questions would provide the expert knowledge which would become the foundation upon which psychiatric services would be constructed.

Between 1955 and 1962, the first Mental Health Project for the Deaf gathered the essential data and made them available to others by publishing them in monograph form (66). That project established a psychiatric clinic for deaf patients needing diagnosis or treatment, it delineated the types of emotional disorders, and developed the most effective treatment plans. However, as the clinic pursued its operations it was often unable to continue the management of patients that required hospitalization, just at the time their need for special treatment was greatest.

One of the most striking discoveries during those early years was that over 230 deaf patients were scattered throughout the 20 hospitals then operated for the mentally ill in New York State. Although the emotional disorders of these patients were so severe as to require hospitalization, neither special treatment facilities nor informed staff was available. Moreover, the difficulties in rehabilitating the mentally ill deaf were almost insurmountable and the lack of community resources and understanding compounded them. Thus many deaf patients remained in hospitals for decades.

Considerations such as these resulted in the demonstration of the comprehensive mental health services for the deaf described in this volume. During its three years of operation (1963-1965), the project established the administrative framework, the modes of ward administration, the courses of treatment, and the special educational and group therapy techniques needed for a total psychiatric program. This program included diagnostic study, psychiatric and psychological workup, outpatient clinic treatment, inpatient hospital care, occupational and social rehabilitation, and psychiatric aftercare. It is described in detail in Chapter 2.

Headquarters for the project was divided between the New York State Psychiatric Institute in New York City, the major teaching and research facility of the state's mental hygiene system, and Rockland State Hospital, a large psychiatric hospital located nearby, in Orangeburg, New York. Organized on a statewide basis, the demonstration program and its facilities were taken over by the State of New York in 1965 as a result of the findings. They are now a permanent part of the state's mental hygiene program.

Personnel and Staff Organization

The goal of the program can be stated simply: to demonstrate that deaf patients can receive and benefit from psychiatric services which are at least equivalent to those available to the hearing. The entire program called for a skilled, dedicated, and hard working interdisciplinary staff versed in manual communication. Trained professional people are never easy to find. Work with the deaf appears at first to be forbiddingly hard, and financial recompense is often insufficient by competitive standards.

Directed by the psychiatric team that had participated in the original seven-year pilot study, the staff was augmented by two ward psychiatrists, a psychologist, an occupational therapist, a vocational counselor, two nurses and 14 ward attendants, as described more fully in Chapter 3. Once these specialists, from physicians to ward attendants, were persuaded to join the team, they developed a fascination, a dedication, and a loyalty which could not have been predicted. Perhaps this was engendered by the inherent intellectual interest of the work; perhaps by the challenge of doing the impossible; or the gratification of success. Possibly it was stimulated by some special emotional satisfaction in reaching the deaf. All who worked with these patients soon became inspired by the feeling that they were a part of an elite group, privileged to do the job. In any event, staff dedication, always noted by visitors, can only bode well for future work.

Ward Patients

At one time there was the dream that all of the deaf patients in New York State mental hospitals, some 250 in number, might be gathered into one building for special care, but administrative discussions established that this would not be economically feasible. Therefore, the inpatient program provided a 30-bed ward, open to patients of both sexes, and criteria for selection necessarily excluded the very disturbed and the very infirm. In the course of the project it became evident that the deaf population of all the New York State hospitals had increased by almost 15 percent in the three year period (excluding the patients on the special ward). Therefore, administrative machinery was set in motion to "rotate" through the ward even chronic patients with long histories of hospitalization in the hope that some of these patients might benefit from the special services, while if necessary they could be returned to their original hospital to make way for others.

Of the first 50 patients treated in the ward, 22 were discharged, three transferred to other hospitals, one died, and 26 remained on the ward. (Chapter 6). Two of the discharged patients were readmitted, one for only a short time. As a rule, the youngest group (ages 16-25) were more profoundly ill and posed the most difficult problems in rehabilitation. Their discharge rate was 25 percent, compared with a rate of nearly 50 percent for all other patients. Some of the older patients left after 20 years or more in other hospitals.

The saving in human potential and money resulting from the rehabilitation of these patients justified the integration of the project into the state's mental health system at the close of this demonstration program. In the smooth transition to a permanent unit, the entire structure of ward staffing and expenses was retained, and all persons previously covered by VRA funds were given New York State civil service status.

Treatment

Once the interdisciplinary staff was recruited and trained to communicate manually with the deaf, various forms of treatment were provided: individual and group psychotherapy, drug and somatic therapies, occupational and recreational facilities, and an educational program for the expansion of communication skills and general knowledge. How this total program was applied to immature, primitive personality, impulsive, and schizophrenic patients has been discussed in detail in Chapters 7 and 8.

Group Therapy

Perhaps the most dramatic achievement of the ward program was the group therapy sessions conducted in signs under the leadership of a skilled doctor and attended three times a week by most of the patients. Everyone who saw the group in action was deeply impressed by the heated interaction, the guided insight, and the growing awareness among patients of self and others. The concept of group therapy developed in the ward, and described in detail in Chapter 8, was so successful that it was extended to aftercare patients, to patients' families, and to students in schools for the deaf.

Occupational Therapy and Vocational Placement

The major characteristics restricting vocational placement of the deaf are emotional instability, social immaturity, educational deficiency, and vocational inefficiency. In the deaf psychiatric patient, the first two are usually present and the last two more often than not. A high degree of personal attention was required in order to obtain the necessary information about each patient and to guide him through the progressive steps which preceded rehabilitation. These included prevocational testing, occupational therapy and workshop, cooperation with state vocational rehabilitation and employment counselors and, in many cases, accompanying a patient on his job interview and sometimes on his earliest trips to his job. Some of the most urgent gaps in the provision of comprehensive mental health services for the deaf are in vocational rehabilitation. Chapter 10 includes a detailed discussion of occupational therapy and vocational adjustment of patients. Chapter 17 proposes the direction of a future program for rehabilitation of the deaf.

Outpatients

During the period 1955-1962, over 200 deaf patients had consulted the outpatient clinic located at the New York State Psychiatric Institute. In the course of the three-year program described in this volume, 119 new patients applied and 96 were accepted for treatment on a regular basis. (Chapter 11).

Communication skills of the patients varied from good in about one-third to practically none in more than one-fifth. About half of all patients used manual language exclusively, one-quarter used a combination of manual and oral, and less than one-fifth used oral exclusively, although often inadequately.

The diagnostic pattern of these patients was somewhat different than that of the group in the previous project. More older and younger patients were seen as the project's facilities became better known and closer relations were achieved with schools for the deaf. Community correctional and welfare agencies also referred more patients to the clinic.

The most common reasons for referral continued to be acute psychiatric illness, poor work adjustment, social conflicts, and family problems. The majority of the patients showed disturbed behavior, but careful examination was required before this could be attributed to severe psychiatric illness in the psychotic range or diagnosed as the manifestations of character problems or transient situational failures. Diagnostic problems have been discussed in detail in Chapter 11, and case histories presented illustrating the situational disturbance, the impulsive character type, and the schizophrenic reaction. Treatment programs for clinic patients included psychotherapy, family involvement, and close cooperation with community agencies. Although many had a poor prognosis on objective psychiatric grounds, a minimum of one-fourth to one-third of all clinic patients improved with treatment.

The Role of the Psychologist

Psychological understanding of the deaf patient can furnish invaluable guides to diagnosis and therapy. An important part of the program, therefore, was the diagnostic testing of all ward patients and of those clinic patients who the psychiatrist felt would benefit from such a workup. Chapter 12 discusses the test battery administered and its evaluation, and it includes a comparison of the results of intelligence testing and Rorschach studies of deaf patients with other studies in the literature. The work contributes valuable information to the body of knowledge regarding the range and quality of cognitive and emotional responses in the deaf.

Staff Training and Education

The continuous recruitment of staff was of utmost importance and efforts toward this end could never be slackened. Without specialized, highly skilled professional and ancillary persons who are willing to devote themselves to the mental health problems of the deaf, any program would be doomed to extinction, or at least the spread of its activities would be grossly limited. Fascination with work in this field followed so often upon familiarity and first-hand experience. For this reason, the project maintained a continuous staff training program which included instruction in sign language, in the psychology and social problems of the deaf, and in their mental health needs. Doctors and other personnel from outlying hospitals who spent varying amounts of time on the project were also instructed. These educational efforts are described in Chapter 13.

Since no public health program can flourish without community understanding and support, the program assumed the responsibility for the education of laymen interested in the problems of the deaf. This led to the formation of a mental health association of the deaf in New York City. Its purpose is to increase the understanding of mental hygiene, to foster programs beneficial to the deaf, and to provide volunteers to work in the rehabilitation of deaf psychiatric patients.

Implications for the Organization of Psychiatric Services

The development of psychiatric programs for the deaf in New York State during the years since 1955 paralleled a growing attention on the part of the psychiatric profession to the unique problems and rewards related to work with this special group.

The recent trend in public health psychiatry has been to recognize the need for specialized services. Units have been established in New York

State for the blind, for narcotics addicts, for alcoholics. The deaf were late in achieving proper treatment, partly because of the reluctance of psychiatrists to tackle the communication barrier; and partly because the deaf tended themselves to deny the need for psychiatric help, even to the extent available to the normally hearing population. As a result, those deaf persons who had psychiatric problems either had not been treated at all or they had been subjected to misunderstanding and faulty diagnosis by persons totally inexperienced with the deaf. In New York State alone many of the deaf patients found in the 21 mental hospitals had remained there for long periods of time without concerted or informed efforts toward therapy.

This demonstration project proved the feasibility of establishing, within the framework of a state mental hygiene system, special facilities and services to care for the psychiatric needs of a deaf population. The administrative integration of the deaf project into the hospital settings was accomplished smoothly and can serve as a model for similar programs elsewhere. It was also demonstrated that an organization providing comprehensive services for the deaf required a quota of professional and ward personnel far above that allotted to the nonspecialized services for the care of hearing mental patients. Nevertheless, the human and economic saving resulting from the rehabilitation of the deaf patients can be easily appreciated by any psychiatrist or counselor who has had contact with the deaf. This alone renders worthwhile the huge efforts that are required.

Theoretical Implications for Psychiatry

The implications of the program for psychiatric management are matched by the theoretical importance of some of the special psychiatric problems that emerged among these deaf patients. As a result of his hearing loss, the deaf child suffers both in the cognitive aspects of learning and thinking and the emotional correlates of communication with his parents in his early years. It was observed in the course of the project that certain unique personality features were present among deaf persons. They often showed a poorly developed ability to understand and care about the feelings of others; and they had inadequate insight into the impact on others of their own behavior and its consequences. With a generally egocentric view of the world and with demands unfettered by excessive control machinery (conscience), their adaptive approach may be characterized as gross coercive dependence. Their preferred defensive reactions to tension and anxiety are typified by a kind of primitive riddance through action (6). Even in the presence of more sophistication, defensive reactions remain at the level of simple projection. This mode of handling tension is reflected in impulsive behavior and the absence of much thoughtful introspection.

To forestall the development of these traits, it is necessary to foster better emotional communication in the home and early school years. Group therapeutic processes may help to modify those traits already developed. However, more and more insight into the developmental patterns of the deaf is needed before conclusions can be drawn. Such concepts as empathy and concern for others, a feeling of affective interaction and its consequences, and community responsibility may be best assimilated by the deaf at certain optimum age levels. Group therapy in the school and in the special ward indicated that progress could be made in this direction.

Implications for Education and Rehabilitation

Now that the demonstration project is a permanent clinical psychiatric program integrated into the state's mental health system, attention can be directed to a major need which came to light in the course of the demonstration program. This is the exploration of the extension of a total mental health approach to the deaf into the areas of education and rehabilitation.

Preventive psychiatry calls for early case finding, referral, and treatment. It also requires proper direction and an emotionally healthy atmosphere both at home and at school where children experience their important childhood and adolescent years.

The need for better education in family living, heterosexual adjustment, and concern for others was evident in the previously conducted research into a cross-section of the normal deaf population (66). The more recent opportunity to pay regular, though brief, visits to a school for the deaf reinforced these observations and provided an opportunity to see what could be done when larger scale resources would become available. Experiments with group therapy for both boys and girls indicated that at least in the older adolescent groups, such interaction enhanced their understanding of themselves and others, and improved their adjustment to school, dormitory, and group living (Chapter 14). It was also observed that teachers and dormitory personnel, and parents, were not fully aware of the emotional needs and problems of the deaf students.

Another major implication was the importance of educating both the hearing and deaf communities toward better understanding of the psychiatric problems of the deaf and proper referral to the service. With turnovers in the leadership of the deaf, new groups constantly must be informed concerning the resources for the mentally ill and the psychiatrically disturbed. Some deaf people have voiced concern periodically that a program such as this stigmatizes them as particularly susceptible to psychiatric illness. They must be reminded that they are no less susceptible than the hearing, but that they have had *no resources at all* for psychiatric help in the past.

In the area of rehabilitation, many problems still exist but the demonstration project clearly delineated their nature. Vocational rehabilitation counseling for the mentally disturbed or convalescent deaf requires double skills on the part of the counselor and intimate collaboration with the psychiatric treatment resource. Throughout this project and its predecessor, cooperation with the state rehabilitation division was excellent and mutual referrals were made. However, it was evident that more direct and intensive liaison between the project and rehabilitation personnel would be essential for the most effective training, job-finding, and job-keeping.

The same close liaison is needed to solve the problems of housing, including temporary placement in halfway houses, day centers, return to families, or placement in apartment and rooming houses. Project staff doctors could guide ward patients while on the ward to problems ahead, and discuss them at aftercare visits. But a larger full-time social service staff would be needed to do the necessary foot work, make the contacts, take the patients to the facilities, and see that the arrangements are cemented (Chapter 15).

Chapter 17

THE DIRECTION OF FUTURE PLANNING: PREVENTION AND REHABILITATION

A successful clinical demonstration program may have two-fold results: first, the development and illustration of new methods of patient care which may then be adapted on a larger scale or more permanent basis; and second, the discovery and delineation of weak points in the program, areas which might be explored in a future project.

The psychiatric program for the deaf in New York State has already moved through two phases: the research, training, and pilot clinical program (1955 to 1962), and the clinical demonstration program of comprehensive mental health services (1963 to 1966) described in this report.

The course of the clinical demonstration revealed two important areas where additional pilot work is needed for deaf psychiatric patients. These are the development of techniques for *preventive psychiatry* and the exploration of a more intensive approach to the problems of *rehabilitation.*

Preventive Psychiatry: Needs

While emotional disorders in children often begin in early years, it is while at school that persons outside of the family may first be able to notice them and take steps to prevent further disturbance. The large number of adolescent patients in the clinic and the ward indicates that preventive psychiatry is sorely needed in the schools, families, and communities where these youngsters grow up. Many of these young patients had been dropped from schools because of their unmanageable behavior resulting from personality disturbance. Through a close working arrangement with one school for the deaf, the project staff had ample opportunity to observe at close range the nature of the emotional problems with which the school administrators had to cope in their efforts to educate and prepare deaf children for productive adult life. Numerous records in the clinic files show that those efforts are often defeated by the psychiatric difficulties of the deaf student. The initial study showed that most deaf persons who became delinquents had exhibited histories of behavior difficulties while in school, and that schools had referred to the clinic many patients with various symptoms of disturbed personality. Direct contact with a school population indicated a large need for individual and group counseling among deaf adolescents and for psychiatric guidance to teachers, cottage parents, and others to assist them in encouraging healthy identifications, attitudes, and development in their charges. Throughout the 10 years of work, the lack of guidance for the deaf in problems of marriage and parenthood was also evident. For example, almost none of the deaf individuals surveyed in interviews of normal deaf persons, and an equally insignificant fraction of those seen in school and clinic, had any meaningful understanding of genetic principles and their consequences for having deaf or hearing children. This points up the need for determining the most effective ways to instill in the deaf the principles of dating behavior, sexual problems, and mate choice.

Preventive Psychiatry: Suggested Program

A number of recommendations can be made for a preventive psychiatric program which would help deaf youngsters and adolescents and their families before signs of emotional distress lead to severe disturbance. The recommendations center around a demonstration program that would (a) provide facilities for early diagnosis in a school population; (b) determine preventive group therapy techniques among adolescents of both sexes; (c) demonstrate methods of group and individual family guidance for the parents and families of students: and (d) indoctrinate and train teachers and cottage parents so they would be able to cope with behavioral problems.

In addition, the program would develop methods for educating the deaf community and all agencies working with the deaf with respect to prophylaxis and early detection of mental illness, and it would establish effective cooperation with the existing mental health program.

Such a demonstration program may focus on a school for the deaf which has already made important use of psychiatric consultants to deal with incipient mental health problems among its pupils. Under supervision of a psychiatrist, a program of early diagnosis can be strengthened by group psychiatric sessions with students of various ages. Preliminary work indicates that these sessions develop understanding of problems of others, ventilate fears and hostilities, and provide an opportunity for specific discussions about community responsibility, family living, sex, dating and courtship, and marriage. Regularly scheduled lectures, individual conferences, and group discussions would implement the goal of educating parents, teachers, and cottage parents. Meetings with deaf leaders, organizations of the deaf, and the psychiatric community at large would help to bring the entire mental health and rehabilitation program into the common spheres of interest of all of these groups, thereby establishing the concern with the deaf as a unique and significant one in the mental health field.

Rehabilitation: Needs

A severe bottleneck in the rehabilitation of deaf inpatients is the absence of community agencies to shelter and receive them when they are ready for discharge. The discharge of many patients had to be delayed until homes could be found which would provide rooms, meals, and supervision. This was the case among inpatients upon leaving the hospital and among outpatients whose home situation was critical. If homes were found that did not fulfill their promise, patients had to return to the hospital. At times, months of preparation were wasted. Efforts to place patients in training programs and in jobs encountered similar obstacles.

To break this bottleneck, a small-scale experiment was developed with Fountain House, a non-profit organization that assists discharged mental patients in the New York City area to re-establish community living by providing them with temporary living quarters shared with other patients who were discharged earlier. The Fountain House program provides patients with a modicum of supervision, training in basic skills, and the support of a helpful group experience while helping them to find adequate permanent living quarters. The cooperative experiment indicated that this approach has a great deal of promise and might be the most economical way of meeting the need. It requires, however, an adequate staff skilled in work with the deaf and sufficiently numerous in proportion to patients to supervise the group interaction and to assist directly in available programs of vocational training and initial on-the-job experiences.

Vocational rehabilitation has suffered similarly because of the need for a specially trained rehabilitation counselor to provide closer liaison on a day-to-day basis and to participate intimately with the hospital and clinic activities. With this kind of liaison, a rehabilitation program that would continue smoothly and uninterrupted into the aftercare phase could be developed for each patient while he is still under treatment.

Rehabilitation: Suggested Program

In order to carry deaf patients effectively through their rehabilitation period, the psychiatric personnel in a clinical program should be supplemented by social workers and rehabilitation counselors specialized in the care of the deaf. Specifically, a demonstration program for reintegration of deaf persons into the community should explore (a) the role and feasibility of a special halfway house and day care program; (b) means of achieving an effective integration between the total psychiatric program and state vocational rehabilitation agencies; and (c) methods for close follow-up and supervision of family, vocational, and community adjustment.

A corps of trained personnel is necessary to coordinate the special halfway house and day care program and to set up personalized services for all deaf patients requiring rehabilitation. These patients include mainly inpatients approaching discharge and selected outpatients who live in a withdrawn fashion. Suitable deaf patients would be taken to visit the halfway houses before discharge, and a social worker trained to work with the deaf would be assigned directly to the patients under this program.

With such trained personnel available for close supervision, it should be possible to utilize more fully community facilities, including day care centers and occupational therapy programs, and to arrange for selected patients of school age to attend school.

Once the acute phase of the illness is past, the psychiatric team and the rehabilitation counselor should share the responsibility for the deaf patients with respect to vocational rehabilitation. Prevocational training—essential in the early stages of rehabilitation—should begin even while the patient is in the hospital and the pace of the program should not slacken with the transition to outpatient status. This work might require the exclusive attention of at least one part-time counselor. Later stages of rehabilitation would require the special efforts of a trained counselor to demonstrate specific methods and results of intensive vocational evaluation, training, and placement of the deaf patient. Such a counselor might participate in the group therapy sessions designed to provide patients with (a) better understanding of vocational choices, job-hunting, and on-the-job behavior; (b) specific training in personal adjustment and general interpersonal relations in the vocational sphere; and (c) preparation for community living.

If the clinical program is to explore the possibility of rehabilitating severely disabled patients who have been hospitalized and inactive for long periods, it must expend further effort to develop methods and facilities for dealing with such patients. If even a modest proportion of these deaf persons return to work, the program will have demonstrated invaluable social and economic gains.

The New York State Program: Third Phase

It is announced with pride and gratification that a plan for a clinical demonstration project including these recommended rehabilitative and preventive psychiatric programs for the deaf was approved on April 1, 1966. With the aid of a new grant from the Vocational Rehabilitation Administration, this demonstration project will develop programs designed to close the gaps that remain, thereby completing the model for a truly inclusive mental hygiene structure. Using the facilities at Rockland State Hospital and the New York State Psychiatric Institute, the staff of the now permanent state clinical program for the mentally ill deaf will organize and supervise this third phase of work.

APPENDIX

APPENDIX

A. Detailed Patient Data

Inpatient Service—Rockland State Hospital

Table I Distribution of Hospital Patients by Age of Onset and Etiology of Deafness
II Distribution of Hospital Patients by Hearing Status
III Distribution of Hospital Patients by Educational Level
IV Distribution of Hospital Patients by Family History of Deafness
V Distribution of Hospital Patients by Communication Used
VI Clinical Data on Deaf Inpatients

Outpatient Clinic—New York State Psychiatric Institute

VII Distribution of Clinic Patients by Age of Onset and Etiology of Deafness
VIII Distribution of Clinic Patients by Hearing Status
IX Distribution of Clinic Patients by Educational Level
X Distribution of Clinic Patients by Family History of Deafness or Consanguinity

TABLE I
Distribution of Hospital Patients by Age of Onset and Etiology of Deafness

Sex and Disposition	Total	Age of Onset					Etiology			
		Born Deaf	Onset before Age 5	Onset between 5-15 Years	Onset after Age 15	Information Not Conclusive	Heredity[1]	Infectious	Trauma	Information Not Conclusive[2]
Male	18	7	8	3	0	0	2	7	1	8
On Ward		3	7	3	0	0	1	6	1	5
Discharged or on Convalescent Care		1	1	0	0	0	0	1	0	1
Transferred		2	1	0	0	0	1	0	0	2
Female	32	10	20	1	0	1	2	15	1	14
On Ward		3	10	0	0	0	0	7	0	6
Discharged or on Convalescent Care		7	8	1	0	0	2	7	0	7
Transferred or Died		0	2	0	0	1	0	1	1	1
Total	50	17	28	4	0	1	4	22	2	22

[1] As indicated by family history

[2] No family history; many are probably deaf due to recessive inheritance

TABLE II
Distribution of Hospital Patients by Hearing Status

Sex and Disposition	Total	Functional Hearing Status		
		Deaf*	Hard of Hearing	Hearing
Male	18	17	1	0
On Ward		12	1	0
Discharged or on Convalescent Care		2	0	0
Transferred		3	0	0
Female	32	29	3	0
On Ward		11	2	0
Discharged or on Convalescent Care		15	1	0
Transferred or Died		3	0	0
Total	50	46	4	0

*Deafness is defined as a stress-producing hearing loss, from birth or early childhood, rendering a person incapable of effecting meaningful and substantial auditory contact with the environment.

TABLE III
Distribution of Hospital Patients by Educational Level

Sex and Disposition	Total	Type of School			Age Entered School			Level of Education				
								Highest Level Achieved			Age Left School	
		Deaf	Hearing[1]	None	5 Years or Earlier	6 Years or Later	Unknown	Elem. School	High School	College	16 or before	17 or after
Male	18	14	3	1	6	1	10	6	9	2	8	9
On Ward		10	2[2]	1	5	1	6	5	7	0	7	5
Discharged or on CC		1	1[3]	0	1	0	1	0	1	1	0	2
Transferred		3	0	0	0	0	3	1	1	1	1	2
Female	32	26	4	2	3	7	20	7	23	0	10	20
On Ward		10	2[2]	1	1	5	5	1	10	0	3	8
Discharged or on CC		14	2[4]	0	2	2	12	4	12	0	5	11
Transferred or Died		2	0	1	0	0	3	2	1	0	2	1
Total	50	40	7	3	9	8	30	13	32	2	18	29

[1] Includes all patients who spent any time in hearing school

[2] Includes one patient who attended a hearing school until age 10, then entered a school for the deaf

[3] Patient attended a hearing school in kindergarten only and was then discharged

[4] Two patients who attended an elementary school for the deaf, then entered a hearing high school

TABLE IV

Distribution of Hospital Patients by Family History of Deafness[1]

Sex and Disposition	Total	Parents			Sibs		Other Close Relatives[2]	
		One Deaf	Both Deaf	Neither Deaf	One or More Deaf	None Deaf	One or More Deaf	None Deaf
Male	18	0	1	17	3	15	1	17
On Ward		0	1	12	0	13	1	12
Discharged or on CC		0	0	2	2	0	0	2
Transferred		0	0	3	1	2	0	3
Female	32	0	0	32	2	30	3	29
On Ward		0	0	13	0	13	1	12
Discharged or on CC		0	0	16	2	14	2	14
Transferred or Died		0	0	3	0	3	0	3
Total	50	0	1	49	5	45	4	46

[1] No history of parental consanguinity

[2] Uncles, aunts, cousins, grandparents, children

TABLE V
Distribution of Hospital Patients by Communication Used

Sex and Disposition	Total	Manual[1]	Oral[2]	Both[3]	Neither
Male	18	2	0	16	0
On Ward		1	0	12	0
Discharged or on Convalescent Care		0	0	2	0
Transferred		1	0	2	0
Female	32	6	2	23	1
On Ward		4	1	7	1
Discharged or on Convalescent Care		1	1	14	0
Transferred or Died		1	0	2	0
Total	50	8	2	39	1

[1] Signs and/or finger spelling exclusively
[2] Speech and/or lip reading exclusively
[3] Chiefly manual, but combined with some speech

TABLE VI
Clinical Data on Deaf Inpatients

Patient	Diagnosis	Age at Onset of Deafness	Family History of Deafness	Communication	Total Period in Previous Hospital	Age on Admission	Months in Deaf Unit	Disposition
F 1	schizophrenia, chronic; several suicide attempts	3 years	none	manual	37 years	71	16	transferred to other ward
F 2	schizophrenia; possible mental deficiency	noted after 1½ years	none	manual	2¼ years	39	33	still on ward
F 3	schizophrenia with mental deficiency	born deaf (?)	none	manual	7 years	32	33	still on ward; ready for discharge
F 4	schizophrenia with mental deficiency	6 years	none	manual, oral	25 years	67	27	convalescent care
F 5	schizophrenia, mixed	born deaf	sister born deaf	manual, oral	10 years	24	13	discharged (left U.S.A.)
F 6	schizophrenia, paranoid	born deaf	none	manual, oral	none	41	11	convalescent care
F 7	schizophrenia, undifferentiated	born deaf	none	manual, oral	5 years	36	30	convalescent care
F 8	schizophrenia, undifferentiated	2 years	none	oral	6½ years	35	20	convalescent care
F 9	psychotic episode with excitement; possible schizophrenia	born deaf (?)	none	manual	5 months	24	33	still on ward; ready for discharge

TABLE VI (Continued)

Patient	Diagnosis	Age at Onset of Deafness	Family History of Deafness	Communication	Total Period in Previous Hospital	Age on Admission	Months in Deaf Unit	Disposition
F 10	schizophrenia, catatonic	noted at 6 months	none	manual, oral	10 years	37	33	still on ward
F 11	psychosis with meningitis	1 year 5 months	none	manual, oral	none	35	18	discharged
F 12	behavior disorder	born deaf	none	manual, oral	2 months	21	15	convalescent care
F 13	schizophrenia, paranoid	born deaf (?)	none	manual, oral	none	38	3	discharged
F 14	primary behavior disorder; simple adult maladjustment	noted at 4 years	none	manual, oral	7 months	20	23	still on ward; ready for discharge
F 15	chronic brain syndrome with behavioral reaction	2½ years	none	manual	none	17	20	convalescent care
F 16	schizophrenia, paranoid	5 years	son born deaf	manual, oral	none	45	7	convalescent care
F 17	psychosis with psychopathic personality; episodes of excitement	2½ years	none	manual	3½ years	31	23	still on ward
F 18	schizophrenia, mixed	1½ years	son born deaf	manual, oral	1 month	28	11	convalescent care

TABLE VI (Continued)

Patient	Diagnosis	Age at Onset of Deafness	Family History of Deafness	Communication	Total Period in Previous Hospital	Age on Admission	Months in Deaf Unit	Disposition
F 19	situationally conditioned adult maladjustment	noted at 7 months	none	manual, oral	3 months	21	16	convalescent care
F 20	involutional psychosis, depressive type	1½ years	none	manual, oral	none	70	5	died
F 21	schizophrenia, mixed	born deaf (?)	none	manual, oral	1½ years	24	10	convalescent care
F 22	involutional psychosis, other types, psychotic depressive reaction	6 months	none	manual, oral	none	59	6	convalescent care
F 23	schizophrenia, paranoid	4 years	none	manual, oral	none	35	10	convalescent care
F 24	schizophrenia, undifferentiated; changed to primary behavior disorder	noted at 6-7 months	none	manual, oral	10 months	17	6	convalescent care
F 25	fugue-like amnesia, episodes with epilepsy	unknown	none	manual, oral	10 years	32	2 days	transferred
F 26	schizophrenia, catatonic	2 years (?)	none	manual, oral	2 years	44	6	still on ward
F 27	schizophrenia, paranoid	noted at 2½ years	none	manual, oral	2½ years	29	6	still on ward

TABLE VI (Continued)

Patient	Diagnosis	Age at Onset of Deafness	Family History of Deafness	Communication	Total Period in Previous Hospital	Age on Admission	Months in Deaf Unit	Disposition
F 28	schizophrenia	noted at 2 years	maternal uncle born deaf	oral	none	39	4	still on ward
F 29	schizophrenia, chronic undifferentiated	noted at 2 years	none	manual, oral	11 years	23	3	still on ward
F 30	schizophrenia, undifferentiated	2-2½ years	none	manual, oral	18 years	55	3	still on ward; ready for discharge
F 31	primary behavior disorder	noted at 1 year	none	none	none	19	2	still on ward
F 32	psychosis due to unknown hereditary causes	born deaf (?)	none	manual, oral	7 months	16	1	still on ward
M 1	schizophrenia, chronic undifferentiated	born deaf (?)	none	manual, oral	7½ years	23	24	still on ward
M 2	schizophrenia, chronic undifferentiated	born deaf (?)	none	manual	2½ years	24	24	still on ward
M 3	schizophrenia, chronic undifferentiated	2½ years	half sister deaf	manual, oral	6¾ years	31	24	still on ward
M 4	primary behavior disorder	born deaf (?)	none	manual, oral	4 years	18	8	transferred

TABLE VI (Continued)

Patient	Diagnosis	Age at Onset of Deafness	Family History of Deafness	Communication	Total Period in Previous Hospital	Age on Admission	Months in Deaf Unit	Disposition
M 5	schizophrenia, paranoid	8 or 11 years	none	manual, oral	20 years	45	21	still on ward ready for discharge
M 6	schizophrenia, simple	born deaf (?)	none	manual	4 years	52	15	convalescent care
M 7	schizophrenia	born deaf (?)	brother born deaf	manual, oral	7½ months	26	11	convalescent care
M 8	primary behavior disorder	after 6 months (?)	none	manual, oral	7¾ years	19	14	still on ward; ready for discharge
M 9	personality trait disturbance, sociopathic trends	noted at about 1 year	none	manual, oral	none	21	11	still on ward; ready for discharge
M 10	schizophrenia, chronic	born deaf (?)	mother born deaf, father deaf since age 10	manual, oral	3½ years	25	10	still on ward; ready for discharge
M 11	schizophrenia, paranoid	3-4 years	none	manual, oral	3 years	28	6	still on ward
M 12	involutional psychosis	2 years	brother deaf since age 4	manual, oral	15 days	60	2	convalescent care
M 13	primary behavior disorder	before 2 years	none	manual, oral	4 months	16	6	still on ward

TABLE VI (Continued)

Patient	Diagnosis	Age at Onset of Deafness	Family History of Deafness	Communication	Total Period in Previous Hospital	Age on Admission	Months in Deaf Unit	Disposition
M 14	schizophrenia, paranoid	10 years	none	manual, oral	6¾ years	40	4	still on ward
M 15	primary behavior disorder	noted at 2 years	4 maternal great-uncles deaf	manual, oral	5 years	16	4	still on ward; ready for discharge
M 16	passive-aggressive personality	8 years	none	manual, oral	23 years	39	2	convalescent care
M 17	primary behavior disorder	1½ years	none	manual, oral	6 years	23	3	still on ward; ready for discharge
M 18	primary behavior disorder	before 2 years	none	manual, oral	2½ years	16	3	still on ward

TABLE VII
Distribution of Clinic Patients by Age of Onset and Etiology of Deafness

Sex	Total	Age of Onset					Etiology				
		Born Deaf	Onset before Age 5	Onset between 5-15 Years	Onset after Age 15	Information Not Conclusive	Heredity	Infectious	Trauma	Other	Information Not Conclusive[1]
Male	73	22	23	1	0	27	10	15	3	1	44
Female	46	13	19	1	0	13	9	12	2	0	23
Total	**119**	**35**	**42**	**2**	**0**	**40**	**19**	**27**	**5**	**1**	**67**

[1] No family history; many are probably deaf due to recessive inheritance.

TABLE VIII
Distribution of Clinic Patients by Hearing Status

Sex	Total	Functional Hearing Status			
		Deaf*	Hard of Hearing	Hearing	No Test Information Available
Male	73	60	3	0	10
Female	46	41	1	0	4
Total	119	101	4	0	14

*Deafness is defined as a stress-producing hearing loss, from birth or early childhood, rendering a person incapable of effecting meaningful and substantial auditory contact with the environment.

TABLE IX
Distribution of Clinic Patients by Educational Level

Sex	Total	Type of School			Age Entered School			Level of Education					
								Highest Level Achieved			Age Left School		Still in School
		Deaf	Hearing	None	5 Years or Earlier	6 Years or Later	Unknown	Elem. School or None	High School	College	16 or before	17 or after	
Male	73	68	11	3	25	15	30	28	36	6	27	33	10
Female	46	36	7	8	12	6	20	3	32	3	3	28	7
Total	119	104[1]	18[1]	11	37	21	50	31	68	9	30	61	17

[1] Includes 9 males and 5 females who attended both deaf and hearing schools and are counted in both columns

TABLE X
Distribution of Clinic Patients by Family History of Deafness or Consanguinity

Sex	Total	Consanguinity in Parents			Parents			Sibs		Other Close Relatives[1]		Information Not Sufficient
		Present	Absent	Information Not Conclusive	One Deaf	Both Deaf	Neither Deaf	One or More Deaf	None Deaf	One or More Deaf	None Deaf	
Male	73	2	36	35	0	7	29	5	31	3	33	37
Female	46	6	24	16	0	0	23	7	16	3	20	23
Total	119	8	60	51	0	7	52	12	47	6	53	60

[1] Uncles, aunts, cousins, grandparents, children

B. Audiometric and Certain Genetic Findings, Patients of Special Medical or Genetic Interest

In addition to the usual hospital admission procedures, supplementary information on all ward patients was obtained during the last year of the project regarding pertinent family history, and audiometric, dermatoglyphic and laterality (handedness) data. Hereditary patterns of deafness and mental illness (including a history of consanguinity) were investigated among their parents, sibs, and other relatives. Prenatal, birth, postnatal, early developmental, clinical, and laboratory findings were studied and sex chromatin, chromosome, X-ray, thyroid, and other appropriate tests were obtained whenever indicated by the clinical or family history. Audiometric tests were administered to 18 male and 21 female patients to determine their degree of hearing loss and to evaluate the possibility of their benefiting from the use of a hearing aid.

Audiometric Patterns

Deafness was defined functionally as being unable to comprehend speech with or without the use of a hearing aid. Almost all patients on the ward had the typical nerve-type hearing loss pattern found in the non-hospitalized early total deafness population. This is characterized by a sharp sloping dip of the audiogram. The exceptions to this pattern included one female patient who was hard of hearing but functioned as a deaf person by attending schools for the deaf and generally identifying with the deaf. Two others, one female and one male, appeared to be hard of hearing with overlays of other organic conditions which did not permit proper evaluation of their hearing loss.

Fingerprints and Handedness

Dermatoglyphic data, including finger and palm print materials, were obtained and analyzed for 18 male and 21 female patients. Laterality tests were also administered to these 39 patients. These included hand preference in writing, use of a key, turning of door knobs, ball throwing, receiving an object given in mid-plane area, sewing, finger and arm folding, and foot preference in walking, kicking a ball, and hopping.

Preliminary analysis of these data showed that within this heterogeneous population (in terms of hospital diagnosis and sex) there were certain suggestive trends, including an increase in the frequency of left-handed patients compared with normals. The fingerprint patterns seemed to show frequencies varying from the normal and suggestive of a leveling of the differences normally seen between the sexes.

Special Medical Investigation

A number of patients with special medical or genetic interest may be described. Five patients received complete thyroid studies due to a suspicion of thyroid abnormality. Protein bound iodine, red cell uptake, radioactive iodine, and X-ray studies were within normal limits in all cases.

One of these patients had a distinctive short stature (height 4′8″, weight 101 lbs.) with a family history of short-statured relatives. These included his father (5′0″), mother (5′2″), and at least six other relatives on the paternal side, a paternal uncle (5′0″), paternal aunt (4′8″), paternal grandmother (5′0″), two paternal great aunts (4′8″ and 4′6″), and a paternal first cousin once removed (4′2″) who was a racing jockey. The patient's family history was negative for mental illness and deafness and his IQ was 74. He was admitted after committing many petty thefts, with a diagnosis of Primary Behavior Disorder, Simple Adult Maladjustment.

In addition to his thyroid studies, physical examination was within normal limits as were the finger and palm print analyses. Sex chromatin and chromosomal studies indicated a normal male complement. Constitutional studies revealed a mesomorphic individual, with very little dysplasia and a heavy masculine (athletic) physique. The family history and other data permitted a diagnosis of familial dwarfism (short stature) with uncertain genetic mode of transmission, and presumably unrelated to the patient's deafness or mental illness.

Another of these patients had a torticollis (bent neck) to the left side, kyphoscoliosis (excessive curvature of the spine) and a low birth weight. She was born to a schizophrenic mother and a borderline schizophrenic father. No other history of deafness or mental illness existed in the family. She was admitted at the time her mother had to be hospitalized.

With her clinical picture suggestive of Turner's syndrome or dwarfism, thyroid studies were performed as well as sex chromatin and chromosome investigation. These were all normal, as were EEG, fingerprint, neurological, and X-ray studies.

A third patient who displayed an unusual physical appearance, and effeminate behavior and mannerisms had a family history that was negative for deafness and mental illness and an IQ of 89.

His father was born in New York City of Italian heritage, while his mother was born in Jamaica, B.W.I. of Spanish, Jewish, Negro, French, and American Indian origin. The boy apparently responded to sound until he was six months old, when he developed a high fever, possibly a meningeal infection. By the age of two it was noted that he failed to respond to sound. He was educated in two schools for the deaf from ages four to nine when he was suspended due to his aggressive, destructive, and effeminate behavior.

Constitutional studies showed a tall, thin, ectomorphic youth with above-average stature but not asthenic. He was not grossly gynandroid in structure, and his genitalia appeared normally developed, but he showed feminoid hip flare greater than average. His joints were not hyperextensive. Detailed analyses of steroids, sex chromatin and chromosomes, EEG, skull X-ray, and finger and palm prints were all within normal limits.

The last patient in this group was a boy of 16 who was 4′11″ tall, weighed 85 lbs., and had an unusual facies with low-set ears, suggestive of a chromosomal anomaly. Chromosome analysis revealed longer long arms of one chromosome in the B group and differences in the centromere location of the No. 2 chromosomes. Further studies of his family were planned. The patient had been transferred from another hospital where he was admitted because of severe temper tantrums, inattentiveness, lack of cooperation, fearlessness, uncontrollability, fire setting, assaultiveness towards a younger brother and sister, enuresis, stealing, and sleeplessness.

C. Interaction Study

Rules for Interaction Interviews

I. The interview consists of five initiatives and five patient responses. If the interview continues for 10 minutes, it is to be terminated at that time even with less than five responses.

II. Initiatives and Responses

a) The questions should be of a non-directive nature rather than referring to specific issues. Non-specific questions afford the patient greater latitude of response than questions directing the patient to a narrow area. One way of maintaining a non-directive approach is to simply repeat the last phrases of the patient's response as the next question.

b) The questions are to be five seconds in length so as to be uniform in duration of stimulation.

c) At the end of patient's response, the interviewer will allow four seconds before presenting the next initiative, to make sure the patient has completed the response. If the patient continues after a pause of less than three to four seconds, his response is to be counted as a part of the preceding response.

d) A response consists of either a verbal or manual or gestural communication on the part of the patient. The response commences when the patient gives indication of readiness to reply. If patient gives such indication but does not actually answer, it is still scored as a response.

e) If there is no response on the part of the patient, either verbal or non-verbal, the interviewer will wait fifteen seconds before proceeding to the next question. The event is scored as no response with zero duration.

f) Interruptions on the part of the patient are to be considered as responses.

Clinical Evaluation of Patients for Interaction Study

The clinical condition of every patient will be recorded every week by a psychiatrist in a definitive clinical note. This record will include the clinical condition of the patient, any possible correlated environmental events affecting the patient and any change in the treatment modality.

The recorder will be a psychiatrist who has the opportunity to observe each of the patients several hours a week and is in a position to be aware of and responsible for all changes in the clinical treatment program. The recorder will not have access to any of the data produced by the interaction records until each stage is completed and the raw data and the clinical condition are compared.

Fig. I INTERVIEWER'S AND RECORDER'S SCHEDULE FOR INTERACTION INTERVIEWS

	INTERVIEWER	RECORDER
MONDAY		
TUESDAY		
THURSDAY		

Fig. II PATIENTS' SCHEDULE FOR INTERVIEWS

(Order in which patients are to be interviewed on consecutive interview-days)

Date 1965	Consecutive interview-day	Patient's number						
		1	2	3	4	5	6	7
	1st	6	2	3	4	1	5	7
	2d	7	2	3	1	4	5	6
	3d	3	1	5	2	6	4	7
	4th	1	4	5	7	6	3	2
	5th	1	6	2	5	4	3	7
	6th	2	6	3	1	5	4	7
	7th	1	6	4	3	7	2	5
	8th	5	6	1	3	4	2	7
	9th	6	3	5	4	7	2	1
	10th	6	3	4	1	2	5	7
	11th	2	4	3	5	1	7	6
	12th	6	5	3	4	7	1	2
	13th	5	6	3	4	2	7	1
	14th	2	3	1	5	4	6	7
	15th	7	5	6	4	2	1	3
	16th	5	2	7	6	1	4	3
	17th	3	6	5	4	2	1	7
	18th	1	7	2	4	3	5	6
	19th	4	1	3	6	2	7	5
	20th	6	7	4	5	2	3	1
	21st	3	6	7	4	2	5	1
	22d	4	6	5	7	1	2	3
	23d	3	2	1	7	6	4	5
	24th	5	7	1	4	3	2	6
	25th	5	2	7	1	4	6	3
	and onward							

Recorder's Responsibilities

1. Show the date of interview on this sheet.
2. Show on the interview-sheet:
    a. Patient's name and number
    b. Day of week, and date
    c. Name of interviewer
    d. Name of recorder
    e. Consecutive day of interview, and order of interview for this patient, this day (1st patient, 2d, 3d, etc.)
3. Move the roll to a definite number, and record on the roll, before the interview begins:
    a. Date and session (BF, before lunch; AF, after lunch)
    b. Patient's name
4. Then proceed with the .nterview.
5. Record on the interview-sheet the patient's mood.

Fig. III SAMPLE SHEET FOR DATA RECORDING

Observations on Interaction

Patient's name____________________ Patient's number____________

Mon	Tu	Wed	Th	Fri	Sat	Date________196__	Consecutive day________ Order of interview (from table)________
___	___	___	___	___	___		

BEFORE LUNCH

Interviewer____________________ Recorder________________

Initiative number	Latency (seconds)	Length of response (seconds)	Patient's mood. Remarks. 1. Very happy 2. Pleasantly cooperative 3. Irritable 4. Sad or depressed 5. Uncooperative
1			
2			
3			
4			
5			
Sum			
Average			
Maximum			
Minimum			
Difference			
Interruptions			

AFTER LUNCH

Interviewer____________________ Recorder________________

Initiative number	Latency (seconds)	Length of response (seconds)	Patient's mood. Remarks. 1. Very happy 2. Pleasantly cooperative 3. Irritable 4. Sad or depressed 5. Uncooperative
1			
2			
3			
4			
5			
Sum			
Average			
Maximum			
Minimum			
Difference			
Interruptions			

Fig. IV
Interaction interviews with a well-integrated schizophrenic patient

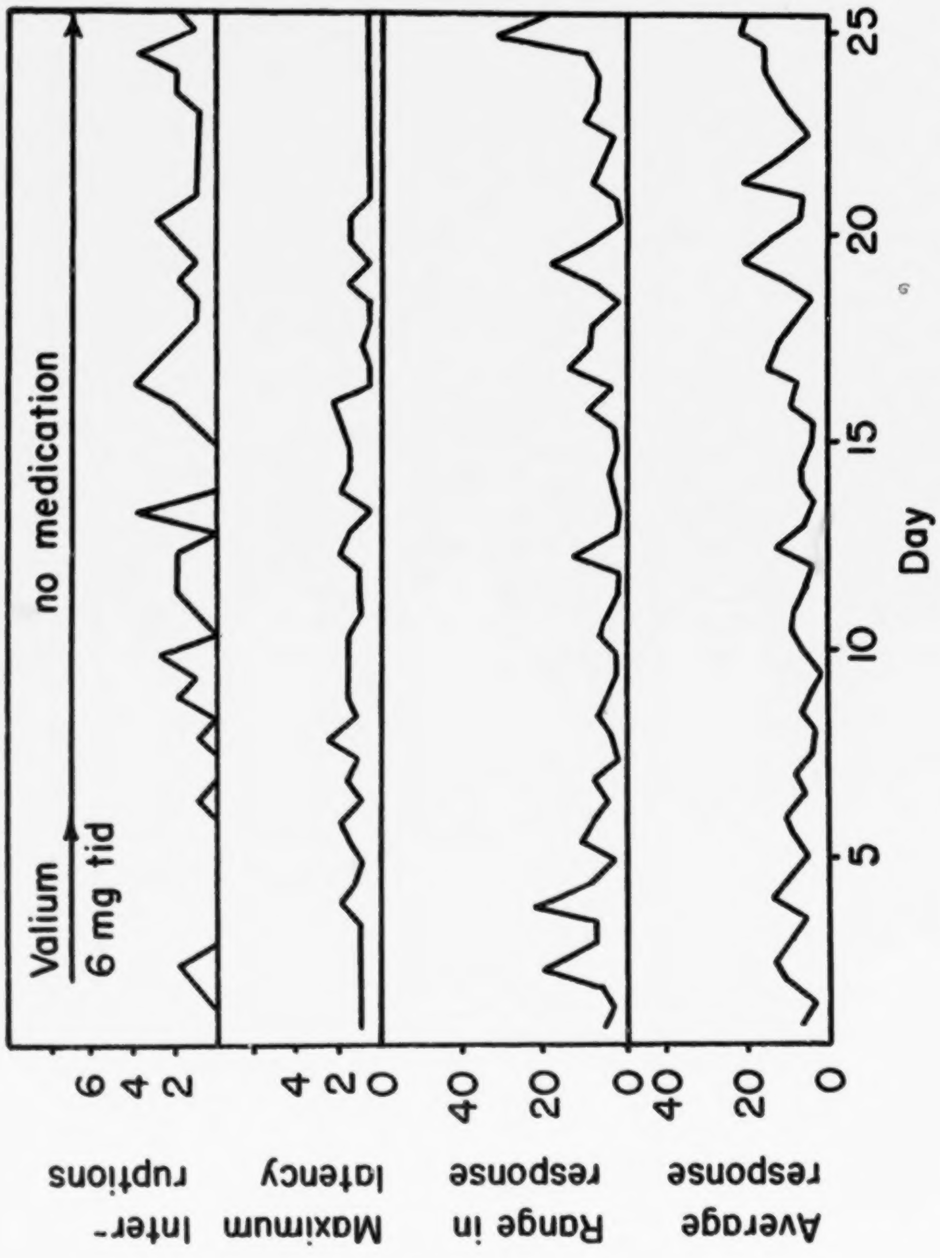
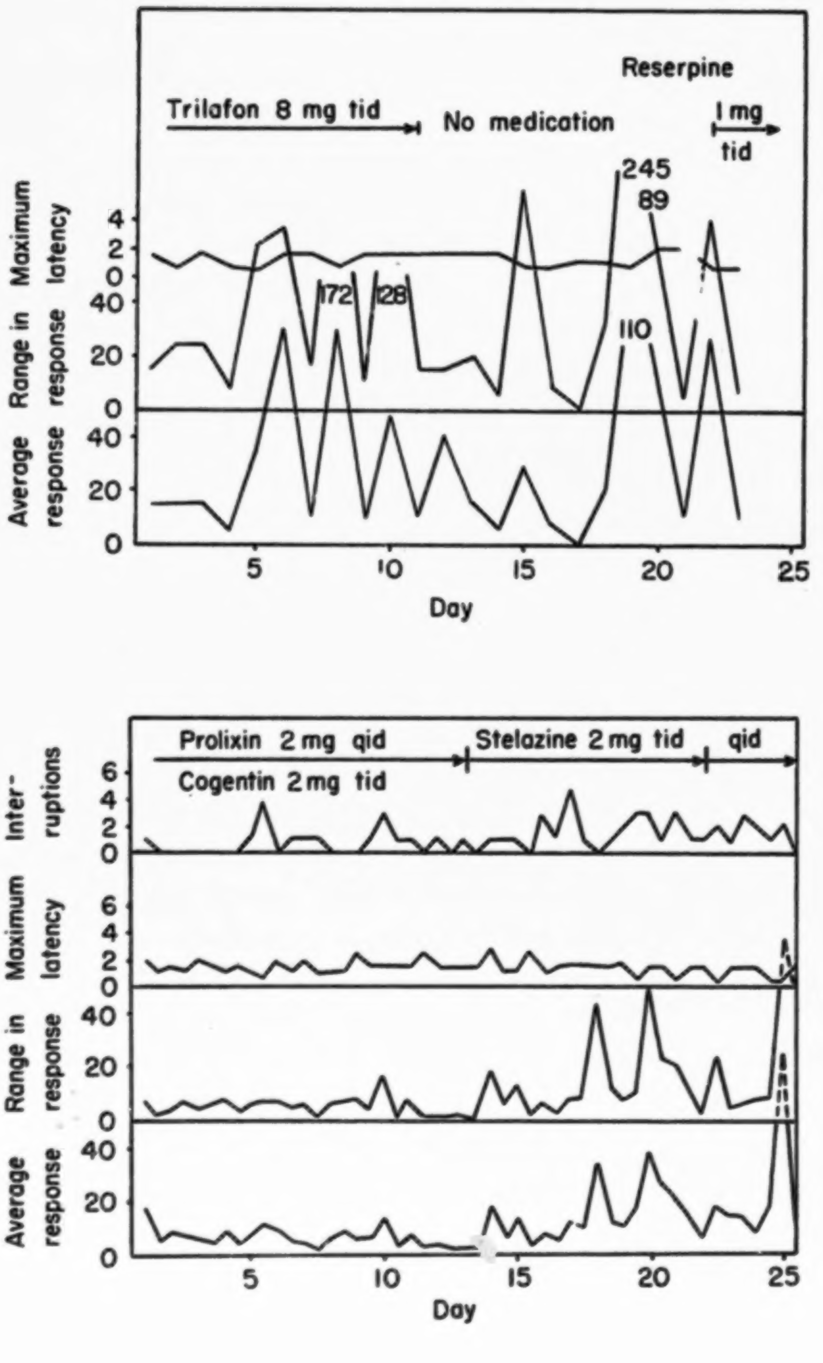


Fig. V Interaction interviews with an unstable decompensated schizophrenic patient



D. Protocols of Group Therapy Sessions

I. Early Stage, First Year of Program

Therapist: How do you feel about being in the hospital?
Nora: The hospital ruined me.
Lena: All the hospitals are the same. You can't do this, you can't do that, you can't do anything.
Helene: We all want to go home. We are not sick.
Louise: The food in the other hospital was better. The meat was better and the potatoes cleaner.
Marian: There are lots of potatoes here. We want more meat and less potatoes.
Lena: Are we to stay here for a long time? The way the doctors talk, it seems we are going to be here for a long time.
Therapist: You sound afraid.
Lena: You bet I am.
Therapist: Of what?
Nora Of the mad woman.
Lena: I'm afraid that I will stay here a long time.
Carolyn: (Proceeded to sign in a diffuse manner for a long time, the major theme being a rather concrete comparison of hospitals and schools. The signs were ambiguous and took quite a while to interpret.)
Therapist: Did you have group therapy in the other hospital?
Nora: They had, but they didn't let me because I was deaf.
Carolyn: I was the only deaf patient in my hospital.
Therapist: What do you think of group therapy?
Lena: It's nice.
Helene: I was afraid to come here at first.
Therapist: How do you feel now?
Helene: So-so.

The group proceeded to talk about Marian's saccharin pills and how she eats the pills and also sugar. Lena and Helene started signing to each other. The discussion continued on food with mostly Helene and Lena participating.

Discussion again centered on patients' desire to go home. The therapist repeatedly tried to develop insight on the patients' part regarding their reasons for being in the hospital; however, the nearest thing to a positive response was Marian's admission that she was not quite all right, but that she would be well within one month's time. When asked how she would become well, she said, "by making my bed and being good on the ward." She was not able to conceptualize except at the most concrete levels of organization.

It appears at this time that the therapeutic purpose of the group has slowed down because of the concreteness of their thought processes. The patients in the group are characterized by an almost complete lack of psychiatric insight and sophistication.

II. Later Stage, Third Year of Program

The session was very well attended, with a lively and intensely interacting group. George was discussed in his absence and it was felt that he is not eager to leave the hospital because he likes the free boarding and lodging that he gets here.

Franklin described how he had rushed to the bathroom to wash off his cosmetics when his grandmother visited him. He says that he cannot help using makeup for "God made me that way."

Ray announced that Kurt proposed to her and said he wants to have two daughters and two sons. She says that she hasn't made up her mind about the proposal. Then she went on to explain how weak and fragile she is, so that she can't do any work. She was asked by Eddie where she gets all the strength to throw chairs around.

Jerry explained how he hated all the rules and regulations of the hospital. It was pointed out to him how he had hated and disobeyed the law and got into trouble with the police repeatedly which resulted in his hospitalization. He was also confronted with the fact that on leaving the hospital he will again come face to face with rules and regulations—how was he going to handle that situation? He thought for a while and then said he was going to be careful in the future.

Eleanor started with an angry tirade against the doctors who conspired to get her back into hospital. Then she went on to speak of her childhood and parents and broke down in profuse tears. She accused her mother-in-law for spoiling her son. When asked why he had left her to live with his grandmother she cut the matter short, saying "That is a different story. We had some quarrels." She then asked the group to vote on the question of their immediate discharge—in one swift round she made everybody say "yes" and then confronted the therapist with the unanimous resolution for discharge of all those who were present in the group. Then turning to the group she declared, "See, he will not discharge anybody because he earns money by keeping people here! All this is a dirty game."

Helene asked why the doctors insist on everybody remaining busy in some way. She said that she did not belong in a place like this, full of crazy people. Asked why she was hospitalized ten times in different state hospitals, she angrily said it was all a mistake. Says she knows how to heal herself of the mischief caused by people who dwell inside her.

Anthony looked relaxed and cheerful after his return from a home visit. He commented that many patients who looked good on the ward got disturbed on going home. He described with great feeling his parting with his two little daughters when he was coming back to the hospital at the end of the home visit. Then he produced a picture of his daughters and circulated it in the group. There were expressions of sympathy and appreciation from most of the group members. The therapist intervened to compliment him at his improvement in recent weeks.

Connie said she plans to get married to her boy friend whom she has never seen. She refused, however, to accept the services of Tommy to make a bouquet for her sweetheart. Helene was the only one to come forward to commend Connie for being an extremely nice person and wondered why she of all persons was in a state hospital. Then Connie was asked to describe how she had beaten up her sister and brother-in-law during her last home visit. After hearing this account, Helene became less enthusiastic in recommending a discharge for Connie.

Rosemarie was asked why she had used obscene language and screamed at her parents when they visited her last Sunday. She said she did this because they brought cakes for her instead of cookies. She was then asked with whom she keeps talking all the time. She explained that she talks with the soul of her sister. Then she became irritable and denounced Eleanor for having dirty feet. There was an uproar of laughter and goodnatured denunciation of Rosemarie at this. Eddie declared that she is really crazy.

Tommy described in great detail all the red, purple, yellow, white, and blue flowers he deals with at the florists where he has been working for the last few weeks. He explained with some feeling and much pride how he makes beautiful bouquets for lovers and sweethearts and for funerals. He then commented that he doesn't make any for his own sweetheart for he has none. At this point he offered to make a bouquet for Connie's imaginary boyfriend. Tommy, who previously used to be received with hostility by the group, got a very attentive and appreciative audience today.

Eddie was concerned about the illness of his father about which he learned today. He wanted to pay a visit home, but conceded that at present it is not possible for his parents to have him home even for a short visit. A little later he talked about the two girl friends, one deaf and one hearing, that he has back home. He appeared confident that both of them are still waiting for him to return. He was determined to make a success of the rehabilitation program at Fountain House.

Lucille started with the declaration that Willie is her sweetheart. This declaration brought forth a distressing scream of protest from Willie. In turn, Lucille became angered and extremely agitated, denounced half the group, including Willie, and walked out of the group only to return in a few minutes. Her attitude amused rather than angered the rest.

Carolyn was asked why she sometimes shrieks for no apparent reason. She said that she does that playfully. Anthony wondered why Carolyn had not been put on any medication in spite of her bizarre behavior. Carolyn strongly rejected the idea that she needed any medication and became glum on further questioning. Eddie explained that if she screams in her characteristic way on the bus while on her way to Fountain House, she will be in trouble. Carolyn first denied that she behaved in any peculiar manner and then declared that it was none of the group's business to talk about it.

Mary, an old patient, wanted the therapist to comment on her latest hairdo and appeared pleased at the compliments.

Anne sat through the group very attentively but without participating actively. Some of the group members expressed disgust with her slowness in acquiring effective communication.

In this session the group displayed a wide range of emotional experience. There were expressions of distrust and suspicion from a paranoid woman who felt relieved only after denouncing the doctors for their conspiracy.

There was the naive impatience of a psychopath with the requirements of law and order. There was sadness in the narration of a nearly recovered schizophrenic. There was a confused phantasy of a borderline mentally defective schizophrenic girl about her imaginary boyfriend. There was the expression of bizarre hallucinatory experience by an acutely psychotic girl. There was an almost compulsive preoccupation with the subject of flowers on the part of a schizophrenic boy who has found a haven in a florist's establishment. There was a demonstration of temper by an easily excitable schizophrenic patient. To all these experiences the group reacted with varying degree of interest and animation. Almost everyone had some comment to offer or some statement to make.

E. Lectures and Reports Made to Various Groups in the Course of the New York State Program

Conference of American Instructors of the Deaf *(Drs. Kallmann, Rainer)*
Conference of Executives of American Schools for the Deaf *(Drs. Kallmann, Rainer)*
International Society for Rehabilitation of the Disabled *(Dr. Altshuler)*
American Personnel and Guidance Association *(Dr. Rainer)*
University of Aarhus (Denmark) *(Dr. Kallmann)*
American Association for the Advancement of Science *(Drs. Rainer, Kallmann)*
Institute for Vocational Rehabilitation Counselors *(Drs. Altshuler, Rainer)*
American Psychiatric Association *(Drs. Altshuler, Rainer)*
Bellevue Psychiatric Hospital *(Dr. Rainer)*
Academy of Ophthalmology and Otolaryngology *(Drs. Rainer, Kallmann)*
International Conference on Differentiation in Current Mating and Fertility Trends *(Drs. Rainer, Kallmann)*
Research Colloquia, New York State Psychiatric Institute *(Dr. Rainer)*
Rehabilitation Workshop for the Deaf *(Dr. Altshuler)*
Downstate Interhospital Conference, New York State Department of Mental Hygiene *(Drs. Altshuler, Rainer)*
Graduate Seminar in Psychology, Columbia University *(Dr. Rainer)*
Past-doctoral Seminar on Psychological Assessment of the Deaf, Gallaudet College *(Dr. Rainer)*
Workshop for Audiologists, Gallaudet College *(Dr. Altshuler)*

University Seminar on Genetics and Evolution of Man, Columbia University *(Drs. Rainer, Sank)*
Eastern Psychiatric Research Association *(Drs. Altshuler, Rainer, Sank)*
International Congress for Psychotherapy *(Drs. Rainer, Altshuler, Kallmann, Farkas, Vollenweider)*
International Conference of Human Genetics *(Dr. Rainer)*
Conference of the National Deaf Childrens Society, London *(Drs. Kallmann, Rainer)*
Residency Training Program, Bowman Gray School of Medicine *(Dr. Kallmann)*
Workshop for Teaching Religion to the Deaf, Seton Hall University *(Dr. Rainer)*
Washington University School of Medicine, St. Louis *(Dr. Altshuler)*
Society of Biological Psychiatry *(Dr. Altshuler)*
Special Planning Conference, VRA *(Dr. Altshuler)*
International Congress on Education of the Deaf *(Drs. Altshuler, Kallmann)*
Workshop for the Orientation of Social Workers to the Problems of Deaf Persons *(Dr. Altshuler)*
Association for Psychoanalytic Medicine *(Dr. Altshuler)*
Rehabilitation Workshop for the Deaf, Southern Baptist Convention *(Drs. Farkas, Altshuler)*
Workshop on Activating Interpreting Services for the Deaf *(Dr. Rainer)*
Michigan Society for Better Hearing *(Dr. Rainer)*

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